Maternal, Infant and Early Childhood Home Visiting Needs Assessment Update

June 30, 2020

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Acknowledgments

The Ohio Department of Health (ODH) contracted with the Health Policy Institute of Ohio (HPIO) to facilitate development of the *Maternal, Infant and Early Childhood Home Visiting (MIECHV) Needs Assessment Update*, including an *Assessment of Ohio's capacity to provide substance use disorder treatment and counseling services ("SUD Assessment")*.

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Part 1. Purpose and overview

Background and purpose

This report provides data and information for inclusion in a comprehensive statewide Maternal, Infant and Early Childhood Home Visiting (MIECHV) Program Needs Assessment Update (referred to as the "Needs Assessment Update"). The Needs Assessment Update is required under section 50601 of the federal *Bipartisan Budget Act of 2018* (Pub. L. 115-123) and as a condition of receiving MIECHV and Title V Maternal and Child Health (MCH) Services Block Grant funding beginning in 2021.[1]

What is the Maternal, Infant and Early Childhood Home Visiting (MIECHV) program?

The MIECHV program is authorized by the Social Security Act, Title V, § 511(c) (42 U.S.C. § 711(c)) to support voluntary, evidence-based home visiting services for at-risk pregnant women and parents with young children up to kindergarten entry.[2] The program is administered as a partnership between the Health Resources and Services Administration (HRSA) and the Administration for Children and Families (ACF).

MIECHV funding is provided to grantees to implement evidence-based home visiting programs as outlined in statute[3] and defined by the U.S. Department of Health and Human Services criteria. Up to 25% of funding is available to implement promising approaches that undergo rigorous evaluation.[4]

MIECHV awardees are required to review and update their statewide needs assessment by Oct. 1, 2020. Awardees were last statutorily mandated to conduct a statewide needs assessment in 2010.[5]

The purpose of this report is twofold, to: (1) provide a current landscape of Ohio's home visiting programs and (2) inform the provision of home visiting services across the state, with a focus on Ohio's most at-risk communities. This report:

- **Identifies communities with concentrations of risk,** where families may have a higher need for home visiting services.
- **Describes the quality and capacity of existing early childhood home visiting programs,** including the number and types of programs, number of families receiving services, extent to which programs are meeting the needs of eligible families and gaps in early childhood home visitation.

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[1] Health Resources and Services Administration. *Maternal, Infant, and Early Childhood Home Visiting Program, Supplemental Information Request (SIR) for the Submission of the Statewide Needs Assessment Update*, no date (expiration date, Nov. 30, 2021). https://mchb.hrsa.gov/sites/default/files/mchb/MaternalChildHealthInitiatives/HomeVisiting/miechv-needs-assessment-update-sir.pdf

[2] Health Resources and Services Administration. *A Guide to Conducting the Maternal, Infant and Early Childhood Home Visiting Program Statewide Needs Assessment Update*. Feb. 2019.

[3] Social Security Act, Title V §511(d)(3), as amended by the Bipartisan Budget Act of 2018.

[4] See note 1.

[5] See note 2. See also Social Security Act, Title V §511, as amended by the Bipartisan Budget Act of 2018.

- **Describes the state's capacity for providing substance use treatment and counseling services** to pregnant women and families in need of such treatment or services.
- **Identifies opportunities for state coordination** of the MIECHV Needs Assessment Update with the:
  - Title V MCH Block Grant program needs assessment.
  - Communitywide strategic planning and needs assessments required under the Head Start Act.
  - Inventories of current unmet needs and current community-based and prevention-focused programs and activities to prevent child abuse and neglect and other family resource services operating in the state required under the Child Abuse Prevention and Treatment Act (CAPTA).

The Health Policy Institute of Ohio (HPIO) was commissioned by the Ohio Department of Health (ODH) to facilitate development of this report by June 30, 2020.

Part 2. Communities with concentrations of risk, families in need of home visiting and advancing equity

This section identifies Ohio's 27 at-risk counties based on data provided by the Health Resources and Services Administration (HRSA). In addition, this section:

- Provides estimates of the number of Ohio families in need of home visiting services.
- Discusses how home visiting can advance health equity in Ohio.

Communities with concentrations of risk

HRSA requires identification of communities with concentrations of risk (referred to as "at-risk communities") in each state's Needs Assessment Update. These communities are considered to have the greatest need for home visiting services in the state based on the risk domains discussed below. HRSA defines a "community" as a county or county-equivalent.

Methods and data sources

Identification of at-risk communities in this report was based on the Needs Assessment Data Summary Excel file (referred to as the "Data Summary") provided by HRSA (see separate Excel appendices A.1 and A.2). The Data Summary provides nationally available, county-level data across measures that fall into five risk domains:

- **Socioeconomic status**, includes poverty, unemployment, high school enrollment/completion and income inequality measures.
- **Adverse perinatal outcomes**, includes preterm birth and low birth weight measures.
- **Substance use disorder**, includes alcohol, marijuana, illicit drug and pain reliever use measures.
- **Crime**, includes crime report and juvenile arrest measures.
- **Child maltreatment**, includes rate of child maltreatment measure.

HRSA provides states with several methodology options for analyzing the Data Summary to identify at-risk communities, or communities with the greatest risk for poor maternal, infant and child health outcomes. This analysis sheds light on where the need for home visiting services is greatest in the state.

Ohio opted to use the simplified method. For more information on the methodology options provided by HRSA and detail on the simplified method, please refer to pages 6-14 of the Maternal, Infant, and Early Childhood Home Visiting Program, Supplemental Information Request (SIR) for the Submission of the Statewide Needs Assessment Update.

Under the simplified method, counties with outcomes that are at least one standard deviation worse than the mean of all Ohio counties for at least 50% of indicators in a domain are considered at-risk for that domain (see figures B.1-B.5 in Appendix B for counties identified as at-risk in each domain). A county is identified as an at-risk community overall for the Needs Assessment Update if it is found to be at-risk in at least two of the five domains.[6]

Identification of at-risk communities

Figure 2.1 identifies Ohio's overall at-risk communities (i.e., counties deemed at-risk for two or more of the domains identified above) based on calendar year (CY) 2017 data. Overall, 27 of Ohio's 88 counties are identified as at-risk communities.

Notably, 60% of Ohio's at-risk communities are Appalachian and among the least populated counties in the state. Ohio's seven most populated counties (Franklin, Cuyahoga, Hamilton, Summit, Montgomery, Lucas and Butler) are also at-risk. This suggests that Ohio's need for home visiting is not isolated to a single county type.[7] However, the majority of Ohio's at-risk population is concentrated in Ohio's urban counties, which are more demographically diverse.

Figure 2.1. **Ohio's at-risk communities, CY 2017**

Note: Counties with outcomes that are at least one standard deviation worse than the mean for all Ohio counties for at least 50% of indicators in a domain are considered at-risk for that domain. Counties deemed at-risk in 2 or more domains are considered Ohio's at-risk communities.
Data years: Socioeconomic status – 2017; Adverse perinatal outcomes – 2013-2017; Substance Use Disorder – 2014-2016; Crime – 2016; Child maltreatment - 2016
Source: HPIO analysis of data provided by the Health Resources and Services Administration

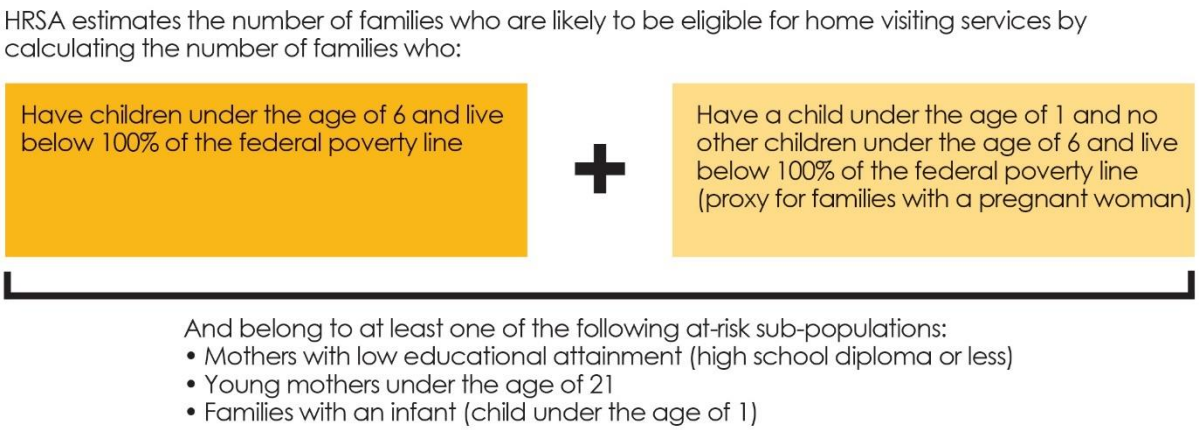
[6] See note 1.
[7] County types in Ohio include urban, suburban, non-Appalachian rural and Appalachian. A map of Ohio counties by county type is in Appendix C.1.

Identifying the estimated number of Ohio families in need of home visiting services

HRSA also provided states with county-level estimates based on CY 2017 Census data from the American Community Survey to identify the number of families in need of home visiting services. The methodology used by HRSA to calculate these estimates is explained in figure 2.2.

Notably, the criteria used by HRSA to estimate the number of families in need of home visiting in Ohio differs from criteria used by Ohio state agencies and organizations to establish home visiting program eligibility (see Part 3 for discussion of Ohio's various home visiting programs and eligibility criteria).

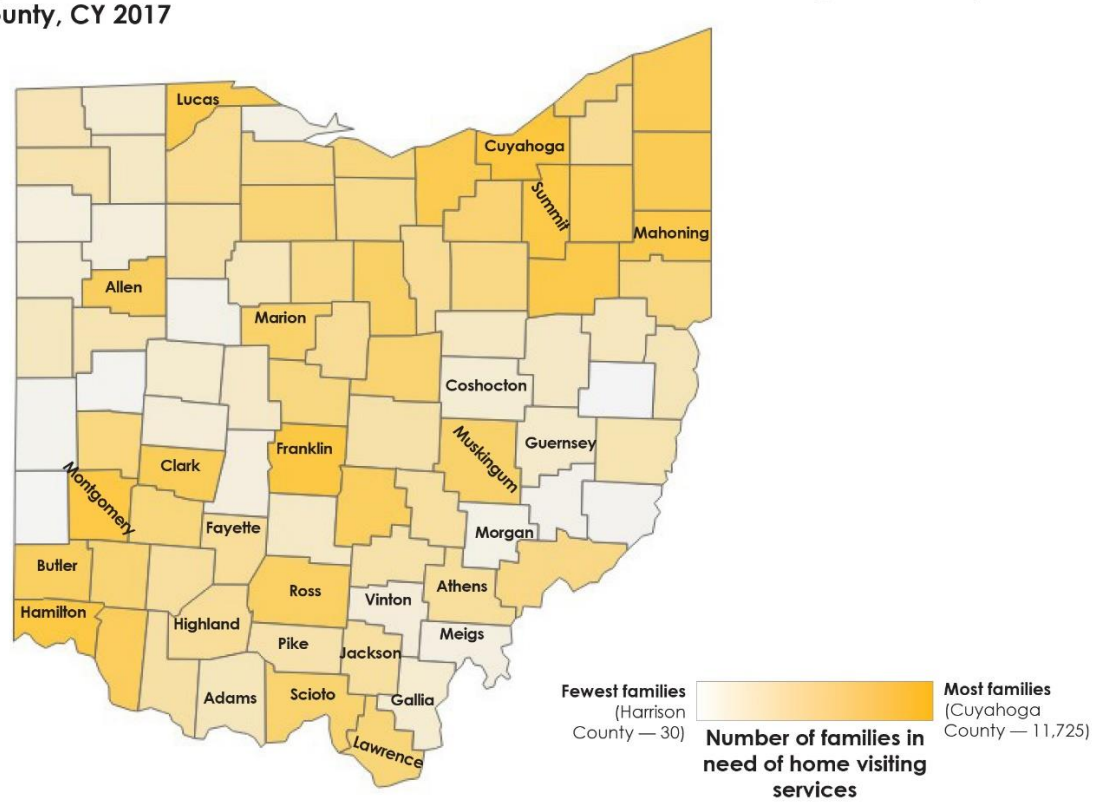
Figure 2.2. **HRSA methodology for calculating estimated need for home visiting services by county**



This data comes from the 2017 American Community Survey (ACS) Public Use Microdata Sample. The data is broken out by Public Use Microdata Area (PUMA) and, using the Missouri Census Data Center's MABLE database, PUMAs are matched to counties. For more information about the methodology for determining the number of families who are likely to be eligible for home visiting services at the county level, see **https://www.healthpolicyohio.org/wp-content/uploads/2019/09/Supplemental-Data_OHIO.xlsx**.

The HRSA analysis indicates that, statewide, 84,035 families were estimated to need home visiting services in CY 2017 (see figure 2.3). County estimates varied widely, ranging from 30 to 11,725 families. Of the 84,035 Ohio families estimated to need home visiting services, 63.2% (53,059 families) are residents of Ohio's at-risk communities.

Figure 2.3. **Estimated number of Ohio families in need of home visiting services, by county, CY 2017**



Note: Labeled counties were identified as at-risk
Source: Health Resources and Services Administration analysis of 2017 American Community Survey data

Counties with the highest and lowest estimated number of families in need are listed in figure 2.4. Unsurprisingly, the five most populated counties had the highest number of families in need and were identified as at-risk communities. None of the counties with the lowest need estimates were identified as at-risk communities.

Figure 2.4. **Ohio counties with the highest and lowest number of families in need of home visiting services, CY 2017**

Counties with the highest estimated number of families in need of home visiting services	Counties with the lowest estimated number of families in need of home visiting services
Cuyahoga* - 11,725	Harrison - 30
Franklin* - 10,271	Preble - 86
Hamilton* - 6,168	Shelby - 102
Montgomery* - 4,917	Monroe - 107
Summit* - 4,454	Darke – 108 (tie)
	Noble – 108 (tie)

*Indicates county is one of Ohio's 27 at-risk communities
Source: Health Resources and Services Administration analysis of 2017 American Community Survey data

Advancing equity through home visiting

Ohio's 2020-2022 State Health Improvement Plan (SHIP) lays out a comprehensive approach to advancing equity and ensuring all Ohioans achieve their full health potential. Early childhood home visiting is included in the SHIP as a strategy that has positive impacts on maternal, infant and child health outcomes, such as kindergarten readiness, adverse childhood experiences, preterm birth, infant mortality and maternal morbidity. Early childhood home visiting is also rated as effective at reducing disparities.

Early childhood home visiting strategies can be most successful in eliminating disparities and advancing equity if:

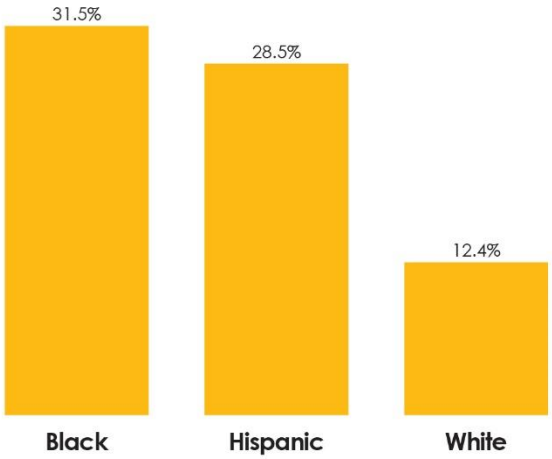
- Comprehensive and complete demographic data and information from home visiting enrollees is collected and reported to identify disparities and measure the outcomes of home visiting interventions specific to at-risk families.
- Resources are allocated and strategies are targeted, tailored and culturally adapted to meet the needs of at-risk counties and other at-risk populations.
- State and local partners actively surface and directly address racism and other forms of discrimination that may be present in the home visiting system and partner systems (i.e., child welfare, behavioral health, early intervention, etc.).

Disparities within Ohio's at-risk counties

Within Ohio's 27 at-risk counties, large disparities exist across many of the measures that are predictive of home visiting need. Disparities in poverty and preterm births provide two examples.

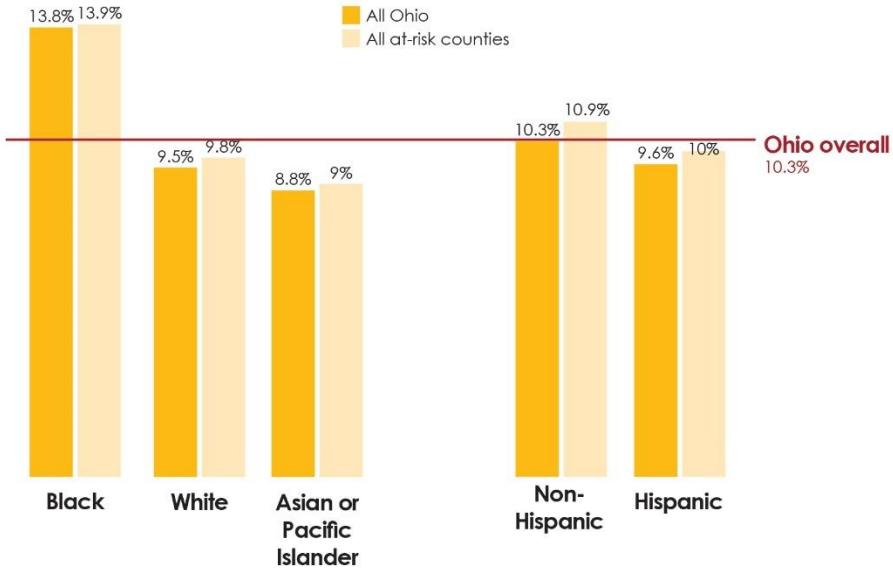
As seen in figure 2.5, more than double the percentage of Black/African-American (31.5%) and Hispanic Ohioans (28.5%) live at or below 100% of the federal poverty level in at-risk communities, as compared to white Ohioans (12.4%). Black/African-American Ohioans living in at-risk communities are also 1.4 times more likely than white Ohioans to deliver a preterm baby (see figure 2.6).

Figure 2.5. **Percent of population at or below 100% of the federal poverty level in at-risk communities, by race/ethnicity, 2018**



Source: HPIO analysis of U.S. Census Bureau, American Community Survey 1-year estimates

Figure 2.6. **Percent of births before 37 weeks gestation (preterm births) in at-risk communities and Ohio overall, by race/ethnicity, 2018**



Source: HPIO analysis of data from the Ohio Department of Health Public Health Data Warehouse. Accessed June 7, 2020 (race) and June 14, 2020 (ethnicity).

This data suggests that within at-risk counties, communities of color have a greater need for home visiting services and the benefits these services can provide. Strategies to strengthen and expand home visiting should allocate resources and tailor strategies to meet the needs of communities most at-risk for poor maternal, infant and child health outcomes. This includes communities of color, as well as other at-risk populations identified in Ohio's Maternal and Child Health Needs Assessment and 2020-2022 State Health Improvement Plan, such as Ohioans with low incomes, low educational attainment, immigrants and refugees and Ohioans living in rural/Appalachian regions of the state.

Part 3. Early childhood home visiting program landscape

Part 3 provides data and information on the quality and capacity of home visiting in Ohio. Part 3 is divided into two sections:

- Reach and capacity of Ohio's home visiting programs.
- Additional information on home visiting capacity and quality in Ohio.

Methods, data sources and stakeholder engagement

Findings in Part 3 draw upon data from the qualitative and quantitative sources described below.

Quantitative data

To assess the quality and capacity of home visiting services in the state, the Health Policy Institute of Ohio (HPIO) analyzed the data listed in figure 3.1.

Figure 3.1. **Quantitative data sources used in the MIECHV Needs Assessment Update analyses**

Data description	Time period of the data	Source
Estimated number of families in need of home visiting services	Calendar year (CY) 2017	American Community Survey data analyzed and provided by the Health Resources and Services Administration
Ohio Department of Health (ODH)-administered and Ohio Department of Medicaid (ODM)-funded home visiting program provider and enrollment data		
Number of households served and enrolled in home visiting services through ODH-administered and Ohio Medicaid-funded home visiting programs	Federal fiscal year (FFY) 2019	ODH
Roster of home visiting service providers for ODH-administered and Ohio Medicaid-funded home visiting programs	FFY 2019	ODH
Number of households on a waitlist for home visiting services through ODH-administered and ODM-funded home visiting programs	Aug. 2019 to Jan. 2020	ODH
Ohio Equity Institute programs receiving funding from ODM through Medicaid managed care organizations	State fiscal year (SFY) 2019 and SFY 2020-2021	ODM
Other early childhood home visiting program provider and enrollment data		
Early Head Start	FFY 2019	Ohio Head Start Collaboration Office
Parents as Teachers and Healthy Families America programs funded by the Ohio Children's Trust Fund	SFY 2019	Ohio Children's Trust Fund
Supporting Partnerships to Assure Ready Kids (SPARK)	2019 and 2020 SPARK Cohorts	SPARK Ohio/the Early Childhood Resource Center
SafeCare Augmented	FFY 2019	YWCA of Greater Cincinnati
Home Instruction for Parents of Preschool Youngsters (HIPPY)	July 2018-June 2019	Children's Home of Cincinnati
Pathways Community HUBs	FFY 2019 or CY 2019	Data provided by each HUB
Healthy Start sites	FFY 2019 or CY 2019	Data provided by each site
Piqua Parents as Teachers	FFY 2019	Piqua Parents as Teachers program

Qualitative data

This report also relies on four sources of qualitative data:

- **Key informant interviews**. To inform an assessment of the quality and capacity of early childhood home visiting in the state, HPIO conducted a series of 15 key informant interviews in March-May 2019.
- **Home visiting provider online survey and webinars**. An online survey was conducted from March 30, 2020 through April 8, 2020 to gather additional information related to capacity, staffing, community resources and readiness from home visiting providers across the state. Two interactive forums (webinars) were held on April 22 and 23 to review the results of the online survey with home visiting providers and gather additional feedback.
- **Maternal and Child Health (MCH)/Maternal, Infant and Early Childhood Home Visiting (MIECHV) Steering Committee**. HPIO and ODH convened 31 child health

and home visiting experts, representing 27 organizations from around the state, to inform the identification of priority needs and performance measures for the MCH block grant needs assessment, as well as to provide input on development of the state's MIECHV Needs Assessment Update.
- **Ohio Department of Health (ODH) Bureau of Maternal, Child and Family Health staff.** HPIO gathered input from ODH staff at multiple points during the process of creating this report.

For additional information on qualitative data sources, see Appendix D.

Reach and capacity of Ohio's home visiting programs

This section provides information on early childhood home visiting models and programs operating in Ohio, including:
- Program administration.
- Funding sources.
- Data on the number of households served through each program.
- Extent to which home visiting programs operating in the state are meeting the needs of Ohioans.

Needs met analysis

As required by the Health Resources and Services Administration (HRSA), HPIO used HRSA estimates of families in need of home visiting to determine the extent to which home visiting programs operating in the state have met the needs of Ohioans. Factors limiting the extent to which Ohio home visiting programs meet the needs of all 84,035 families estimated to be in need of home visiting services include, but are not limited to, home visiting program eligibility requirements, funding limitations and provider capacity. Additional factors are explored throughout this section.

MIECHV funding is provided to grantees to implement evidence-based home visiting programs as outlined in statute[8] and defined by the U.S. Department of Health and Human Services (HHS) criteria. There are six home visiting models operating in Ohio identified as "evidence-based" by the HHS Home Visiting Evidence of Effectiveness (HomVEE) review[9]:
- **Early Head Start (EHS) Home-Based Option**: Provides intensive, comprehensive child development and family support services to pregnant women and families with children under age 3 with incomes below the poverty level.
- **Healthy Families America (HFA)**: Reduces child maltreatment, improves parent-child interactions and children's social-emotional wellbeing and promotes school readiness beginning prenatally or within a child's first three months, continuing until between ages 3 and 5.
- **Home Instruction for Parents of Preschool Youngsters (HIPPY)**: Family literacy and home visiting program for low-income families, designed for children ages 2-5, to improve school readiness.

[8] Social Security Act, Title V §511(d)(3), as amended by the Bipartisan Budget Act of 2018.
[9] "Effectiveness Research." U.S. Department of Health and Human Services Home Visiting Evidence of Effectiveness. Accessed August 28, 2019. https://homvee.acf.hhs.gov/effectiveness

- **Nurse-Family Partnership (NFP)**: Improves prenatal, maternal health and birth outcomes, child health and development and families' economic self-sufficiency through trained registered nurses working with first-time, low-income mothers and their children beginning prenatally and continuing until the child is age 2.
- **Parents as Teachers (PAT)**: Provides parents with child development knowledge and parenting support, provides early detection of developmental delays and health issues, prevents child abuse and neglect and increases children's school readiness.
- **SafeCare Augmented**: Prevents and addresses factors associated with child abuse and neglect.

Other home visiting programs operating in Ohio: (1) have evidence of positive outcomes, but have not undergone the HHS HomVEE review, (2) are currently undergoing HomVEE review and have not yet been designated as evidence-based by HHS or (3) are not HHS HomVEE-designated. The intensity of the services provided through HomVEE and non-HomVEE models varies greatly depending on the model or program's objectives and goals.

When available, data and information is provided in this section for:
- HomVEE programs administered by the Ohio Department of Health.
- HomVEE programs funded through the Ohio Department of Medicaid and the Ohio Department of Job and Family Services/Ohio Children's Trust Fund.
- Other HomVEE programs operating throughout Ohio.
- Non-HomVEE home visiting programs operating in Ohio.

Duplication in the data

Obtaining unduplicated counts of households served by all home visiting programs is challenging because not all programs report to a centralized data system.

It is possible for a family to be served by more than one HomVEE program simultaneously and, therefore, result in duplicated counts of households served. However, because of efforts to coordinate services and referrals among HomVEE programs, duplication of households in the HomVEE data analysis should be minimal.[10] The Ohio Comprehensive Home Visiting Integrated Data System (OCHIDS), administered by ODH, does not allow for a family to be enrolled in multiple ODH-funded and -supported programs at the same time.

There is a higher likelihood of duplication of data in households served through non-HomVEE home visiting programs. For the purposes of this Needs Assessment Update, and to avoid duplicative household counts, analyses of HomVEE and non-HomVEE programs were conducted separately.

HomVEE models operating in Ohio

Figure 3.2 lists the six HomVEE models operating in Ohio and provides information on funding entities and the number of counties and households served through each.

[10] Information provided by the Ohio Department of Health.

Figure 3.2. **HomVEE home visiting models operating in Ohio, as of June 2020**

Model	Primary funding entity(ies)/program(s)	Number of counties with a provider	Number of households served
Healthy Families America	• Ohio Department of Health (ODH) and federal MIECHV program • Ohio Department of Medicaid (ODM) • Ohio Children's Trust Fund (OCTF) • Federal funding*	70	7,544 (FFY 2019)
Nurse-Family Partnership	• ODH (including MIECHV) • ODM	6	1,518 (FFY 2019)
Parents as Teachers	• ODH • OCTF • United Way of Miami County and Piqua City Schools**	18	826 (FFY 2019)
Early Head Start (Home-based option)	Federal funding	40 programs operating in 59 counties in FFY 2019	4,126*** (FFY 2019)
SafeCare Augmented	Hamilton County Department of Job and Family Services	Hamilton County (as of March 2020)	90 (FFY 2019)
Home Instruction for Parents of Preschool Youngsters (HIPPY)	Private funding	3 counties as of March 2020 (Hamilton, Brown and Clermont)	111 (July 2018-June 2019)

*My Baby & Me (Healthy Start program in Franklin County) served 10 households through HFA in FFY 2019
**Funds the Piqua Parents as Teachers program in Miami County
***Due to data availability, Early Head Start total served includes counts of children served in 44 counties (2,968) and funded enrollment numbers for 15 other counties (1,158)
Note: Data from OCTF was from SFY 2019 (124 served through PAT and 22 served through HFA).
Sources: HFA, NFP and PAT data is from the Ohio Department of Health (FFY 2019), Ohio Children's Trust Fund (SFY 2019), Columbus Public Health (FFY 2019) and Piqua Parents as Teachers (FFY 2019). Early Head Start data is from the Ohio Head Start Collaboration Office (FFY 2019), SafeCare Augmented data is from the YWCA of Greater Cincinnati (FFY 2019) and HIPPY data is from the Children's Home of Cincinnati (July 2018-June 2019).

HomVEE programs administered by the Ohio Department of Health (HMGHV HomVEE)

Ohio's Help Me Grow (HMG) program has two components: HMG home visiting (HMGHV) and HMG Early Intervention. ODH administers HMGHV for at-risk women and families, and the Ohio Department of Developmental Disabilities (DODD) administers HMG Early Intervention for children with developmental delays or disabilities. This section focuses on HMGHV. For more information on HMG Early Intervention, see page 28.

ODH administers four home visiting models/programs as part of HMGHV. Of those four, three are HomVEE-designated evidence-based models, as indicated with an asterisk:

- Healthy Families America (HFA)*
- Parents as Teachers (PAT)*
- Nurse-Family Partnership (NFP)*
- Moms and Babies First

Data and information on ODH's HMGHV HomVEE programs (HFA, PAT and NFP) are reviewed in this section. Information on Moms and Babies First programs is on page 27.

Agencies contract with ODH to provide home visiting services through HMGHV (referred to as HMGHV providers). In FFY 2019, the vast majority of HMGHV HomVEE providers implemented the HFA model (see figure 3.3).

Figure 3.3. **Number of HMGHV HomVEE providers by model, FFY 2019**

Model	Number of HMGHV providers operating the model in FFY 2019
Healthy Families America	60
Parents as Teachers	12
Nurse-Family Partnership	4
Total number of providers	**71***

*Some HMGHV providers operate more than one HomVEE model.
Note: These counts include providers that received HMGHV state funding, MIECHV federal funding or both in FFY 2019. Of the 71 providers, 18 received both HMGHV and MIECHV funding, 50 received only HMGHV funding, and three received only MIECHV funding.
Source: Data provided by the Ohio Department of Health

HMGHV HomVEE program eligibility

Per the Ohio Administrative Code, to be eligible for HMGHV services through one of the HomVEE programs, pregnant women or families with a child under age 2 must have an income at or below 200% of the federal poverty level (FPL) and meet one or more of the following criteria:

- Pregnant woman under age 21.
- Previous preterm birth.
- History of child abuse, neglect or interactions with child welfare.
- History of substance use or demonstrate a need for substance use treatment.
- Child with a diagnosed developmental delay.
- Tobacco user.
- Active duty military member.
- History of unstable housing or homelessness.
- Caregiver with a history of depression or other diagnosed mental health concerns.[11]

The HFA and NFP home visiting models have additional eligibility criteria. HFA requires families to be enrolled prenatally or within the child's first three months. NFP is only available to first-time mothers, and a woman must be enrolled and receive her first home visit before the end of the 28th week of pregnancy.[12]

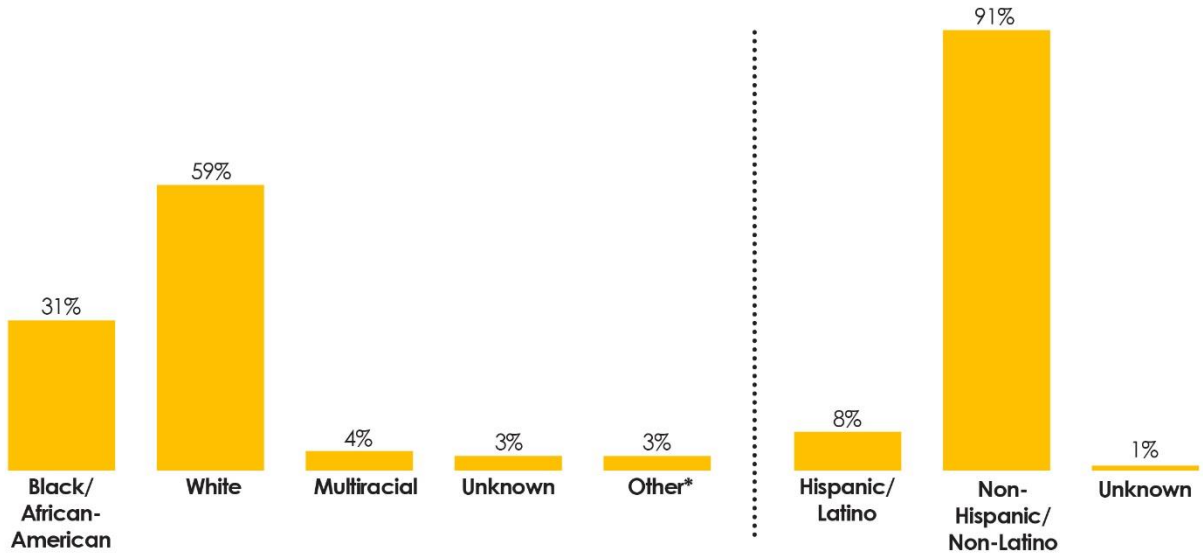
ODH's current regulations require that 85% of a HMGHV provider's capacity is used to serve families who enroll prenatally or with a child not exceeding six months of age at the time of referral. The remaining 15% may be used to serve families with a child up to age 2.[13] However, model eligibility rules may be more restrictive, as described above.

[11] Ohio Administrative Code (OAC) § 3701-8-02
[12] "Effectiveness Research." U.S. Department of Health and Human Services Home Visiting Evidence of Effectiveness. Accessed August 28, 2019. https://homvee.acf.hhs.gov/effectiveness
[13] OAC § 3701-8-02

Spotlight on individuals and families receiving home visiting services through ODH HMGHV HomVEE programs

In FFY 2019, there were 8,755 pregnant women and families enrolled in ODH HMGHV HomVEE programs.[14] Figure 3.4 highlights the racial and ethnic diversity of enrollees. Nearly one-third were Black/African-American (31.3%), 4% were multiracial and 8% were Hispanic/ Latino.[15] As highlighted on page 10, Ohioans of color are at higher risk for poor maternal, infant and child health outcomes and, as a result, have a greater need for home visiting services.

Figure 3.4. **Pregnant women and primary caregivers enrolled in ODH-administered HomVEE home visiting programs in FFY 2019, by race and ethnicity** (n=8,755)



*Other races includes American Indian/Alaskan Native, Asian and Native Hawaiian/Pacific Islander
Note: Includes HomVEE programs funded through HMGHV state funding and MIECHV federal funding
Source: Ohio Department of Health

Other characteristics of HMGHV HomVEE program enrollees are as follows:

- A total of 71.5% had incomes at or below the federal poverty level (FPL).
- Nearly 7% (6.9%) of HMGHV HomVEE home visiting participants in FFY 2019 were non-English speakers.[16]
- Average maternal age at enrollment in state-funded HMGHV HomVEE programs was 25.5 years, and 26.9 years for MIECHV-funded programs.
- A total of 59.3% of pregnant women and primary caregivers served through HMGHV HomVEE programs were first-time caregivers.[17]

Collecting and reporting on comprehensive and complete demographic data and information, including race, ethnicity, income and primary language of home visiting enrollees, is a critical first step to eliminating disparities and advancing equity. However,

[14] Data provided by the Ohio Department of Health. This only includes families enrolled in HFA, NFP and PAT programs. Moms and Babies First programs are not included.
[15] Ibid.
[16] The two counties with the highest percentages of non-English speaking enrollees were Hamilton and Franklin, which contain two of Ohio's largest cities – Cincinnati and Columbus, respectively.
[17] Data provided by the Ohio Department of Health on May 15, 2020.

it is equally important to measure and report on the outcomes of home visiting interventions for these at-risk populations. For discussion of home visiting data gaps, see page 45.

For additional information on ODH HMGHV enrollees, see Appendix E.

HMGHV HomVEE funding

HMGHV HomVEE programs are primarily funded by Ohio General Revenue Fund (GRF) appropriations and augmented with federal MIECHV dollars.

ODH reimburses providers using a fee-for-service payment rate structure up to certain caps set in provider agreements. Home visiting provider rates were increased on January 1, 2020, with payments retroactive to July 2019. The licensed rate for registered nurses and licensed social workers increased from $13.50 to $19.30 per 15-minute increment. The rate for other, unlicensed home visitors increased from $12.00 to $17.15 per 15-minute increment.[18] The following activities are eligible for reimbursement:

- Delivering home visits (including conducting comprehensive assessments, developing and managing a family's goal plan, delivering parenting education using an approved curriculum and referral for follow-up activities).
- Travel to and from a completed home visit.
- Preparation time to complete a home visit.
- Data entry and documentation.[19]

In response to the COVID-19 pandemic, ODH expanded the definition of a home visit to include telehealth (phone, video, text) and drop-in visits.[20]

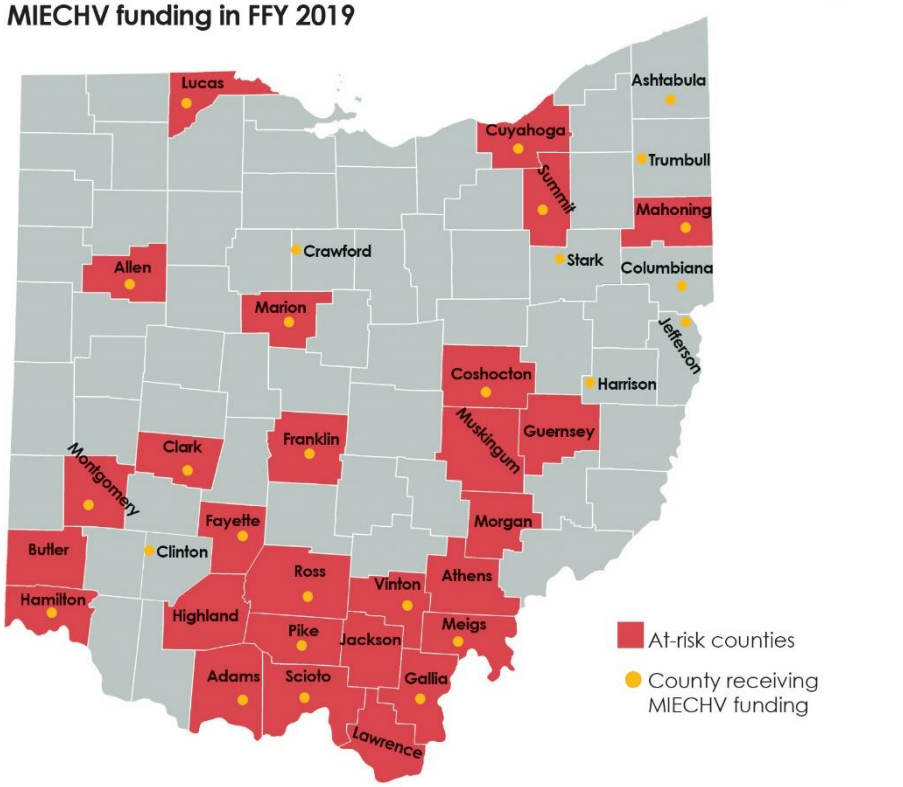
In FFY 2019, 21 HMGHV providers operating HomVEE models received MIECHV grant funding to serve 27 counties (see figure 3.5).[21] Awardees receive $3,300 for each family served through HFA and $4,000 for each family served through NFP. Currently, MIECHV funding only goes to HMGHV providers operating HFA or NFP.[22] In FFY 2019, a total of 2,206 households were served with MIECHV funding (533 families through NFP and 1,673 families through HFA). Notably, HMGHV providers who receive MIECHV funding do not also receive ODH fee-for-service payments.

[18] Information provided by the Ohio Department of Health on May 4, 2020.
[19] OAC § 3701-8-09
[20] See note 15.
[21] Data provided by the Ohio Department of Health on March 3, 2020.
[22] Recommendations of the Governor's Advisory Committee on Home Visitation, March 2019.

Figure 3.5 highlights the 27 counties identified as at-risk communities in this Needs Assessment Update. Eight of these counties did not receive MIECHV funding in FFY 2019: Athens, Butler, Guernsey, Highland, Jackson, Lawrence, Morgan and Muskingum.

Conversely, eight counties receiving MIECHV funding in FFY 2019 were not identified as at-risk communities: Ashtabula, Clinton, Columbiana, Crawford, Harrison, Jefferson, Stark and Trumbull.

Figure 3.5. **Ohio's at-risk communities and other counties receiving MIECHV funding in FFY 2019**



Source: At-risk counties derived from HPIO analysis of data provided by the Health Resources and Services Administration; MIECHV funding data from the Ohio Department of Health

Ohio does not intend to provide any additional data regarding the definition of at-risk status. Therefore at this time, those eight counties will be ineligible for future MIECHV funding.

HMGHV HomVEE households served and needs met analysis

In FFY 2019, there were 8,755 households served through an ODH HMGHV HomVEE program in 86 of Ohio's 88 counties (see figures 3.6). This represents 10.4% of the 84,035 families estimated to need home visiting services.

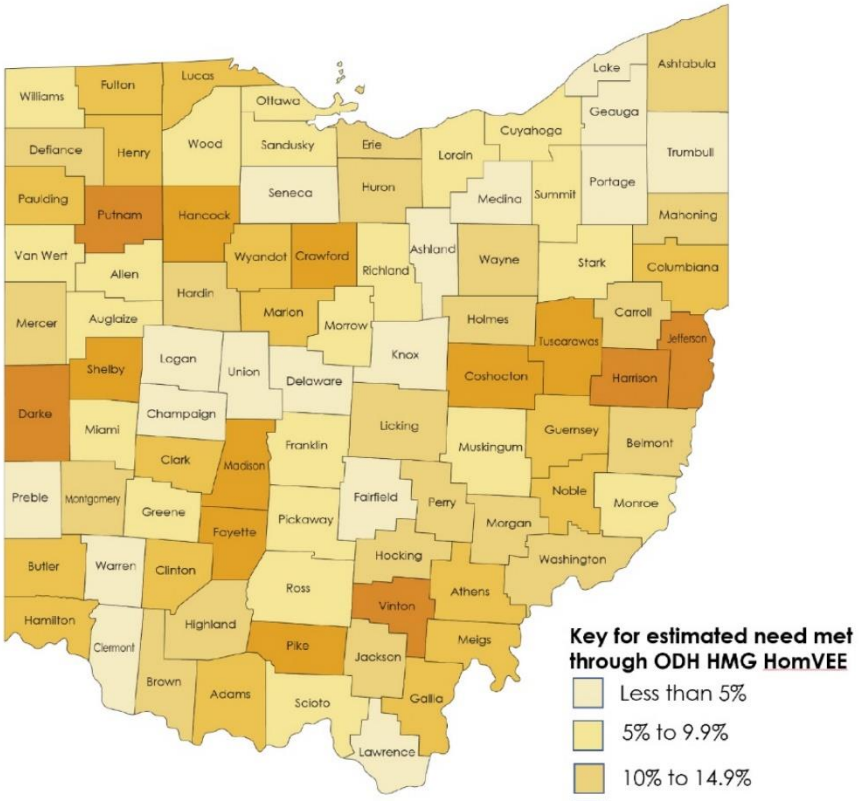
Figure 3.6. **Reach of HMGHV HomVEE programs, FFY 2019**

HomVEE model	Number of counties with at least 1 household served	Number of households served
Healthy Families America (HFA)	79	7,384
Nurse-Family Partnership (NFP)	9	749
Parents as Teachers (PAT)	22	622
Total	**86**	**8,755**

Note: Five counties did not have an ODH-contracted HMGHV HomVEE provider: Champaign, Delaware, Lawrence, Logan and Preble. In certain circumstances, a provider will serve households in a county where there is not a contracted provider. In FFY 2019, one household was served in Champaign County, six in Delaware County and one in Preble County. Lawrence and Logan Counties were the only counties with no households served through an ODH HMGV HomVEE program.
Source: Ohio Department of Health

Figure 3.7 shows the percent of estimated need met through ODH HMGHV HomVEE programs in each county. For a detailed table by county, see Appendix E. The estimated percent of need met ranged from 0% in Lawrence and Logan Counties to 220% in Harrison County. The second highest percent of need met was Vinton County at 68.2%. Seventy-five of Ohio's 88 counties had less than 25% of their estimated need met through ODH's HMGHV HomVEE programs. Fifty-eight counties had less than 15% of their estimated need met.

Figure 3.7. **Estimated percentage of need met through ODH HMGHV HomVEE programs, by county, FFY 2019**



Source: Estimate of families in need of home visiting services derived from 2017 American Community Survey data provided by the Health Resources Services Administration; Number of families served data is from the Ohio Department of Health and includes families served through HMG Home Visiting, including MIECHV-funded programs (HFA, NFP and PAT) for FFY 2019.

In July 2020, ODH will begin administering home visiting through six home visiting regions (see Appendix C.2 for a map of home visiting regions). For an estimated percentage of need met through ODH HMGHV HomVEE programs by home visiting region, see Appendix E.

At-risk communities

A total of 5,618 households in the 27 at-risk communities were served through an ODH HMGHV HomVEE program in FFY 2019. This represents 10.7% of the estimated number of families in need of home visiting services in those counties (52,472).

The percent of need met in at-risk counties by ODH HMGHV HomVEE programs varied from 0% (Lawrence) to 68.2% (Vinton) in FFY 2019. Figure 3.8 shows the at-risk counties with the highest and lowest percentages of need met. All at-risk counties with the highest percentages of need met are in the southern central and southeastern portions of the state. Three of Ohio's most populated counties (Summit, Franklin and Cuyahoga) are among the at-risk counties with the lowest percentages of need met.

Figure 3.8. **At-risk communities with the highest and lowest percentages of estimated need met through ODH-administered HomVEE programs**

At-risk communities with the highest percent of estimated need met	At-risk communities with the lowest percent of estimated need met
Vinton (68.2%)	Lawrence (0%)
Fayette (34.8%)	Summit (5.2%)
Pike (33.2%)	Franklin (5.3%)
Coshocton (31.2%)	Cuyahoga (6.3%)
Gallia (24.4%)	Ross (6.8%)

Sources: Estimates of families in need of home visiting services derived from 2017 American Community Survey data provided by the Health Resources Services Administration; Number of families served data is from the Ohio Department of Health and includes families served through HMG Home Visiting, including MIECHV-funded programs (HFA, NFP and PAT) for FFY 2019

HomVEE programs funded by the Ohio Department of Medicaid (ODM-funded HomVEE)

The Ohio Department of Medicaid (ODM) provides funding for infant mortality disparity reduction programs in nine Ohio communities (i.e., Ohio Equity Institutes or "OEIs"). Funding from Medicaid is channeled through Medicaid managed care organizations (MCOs) to community-based organizations in the OEIs. All funded programs must implement one or more of the following evidence-based interventions:

- Home visiting.
- Community health workers.
- Centering Pregnancy.

ODM-funded HomVEE households served and needs met analysis

ODM does not require implementation of HomVEE models for home visiting. However, some funded OEI programs utilize the HFA and NFP models. In FFY 2019, a total of 897 households were served through Medicaid-funded HomVEE programs; 769 households were served through NFP, and 128 households were served through HFA. Most of the households served through HomVEE programs funded by ODM were in at-risk communities (see figure 3.9).

Figure 3.9. **Households served through Medicaid-funded HomVEE programs, FFY 2019**

Model	Households served through HFA	Households served through NFP
At-risk communities (counties)		
Butler	0	30
Clark	0	1
Cuyahoga	0	215
Franklin	0	130
Hamilton	0	1
Mahoning	0	52
Montgomery	124	264
Summit	0	49
Other counties*		
Greene	0	1
Lake	0	1
Miami	1	1
County data missing	3	24
Total	**128**	**769**

*Includes families that were transferred between home visiting programs, but who were at one point served by a Medicaid-funded HomVEE program in one of the nine Ohio Equity Institute communities.
Source: Ohio Department of Health

The percent of need met through ODM-funded HomVEE programs is 1.1%. When combined with households served through ODH HMGHV HomVEE programs, 11.5% of statewide need for home visiting services is met (see figure 3.10).

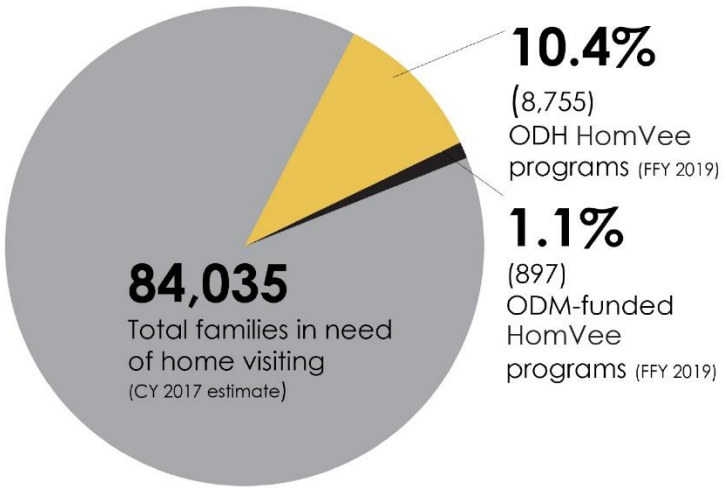
Other HomVEE programs

In addition to the ODH HMGHV programs and ODM-funded programs described above, the following HomVEE programs also operate in Ohio.

HFA and PAT programs funded by the Ohio Children's Trust Fund (OCTF)

OCTF is the only public funding source dedicated to child abuse and neglect prevention in the state and is Ohio's Community Based Child Abuse Prevention (CBCAP) lead agency established under Title II of CAPTA.

Figure 3.10. **Estimated percentage of need met through ODH HMGHV and ODM-funded HomVEE programs, FFY 2019**



Source: Estimate of families in need of home visiting services derived from 2017 American Community Survey data provided by the Health Resources Services Administration; Number of families served data is from the Ohio Department of Health and includes families served through HMG Home Visiting, including MIECHV-funded programs, and Medicaid-funded programs (HFA, NFP and PAT) for FFY 2019

In SFY 2019, OCTF granted over $296,000 to home visiting providers. Of this, $63,850 was allocated to fund HFA programs in three counties (Columbiana, Mahoning and Trumbull), serving 29 adult caregivers and their children. Another $216,274 was allocated to fund PAT programs in three counties (Cuyahoga, Summit and Sandusky), serving 124 caregivers and their children.[23]

Early Head Start (EHS) Home-Based Option
The EHS home-based option is a HomVEE-designated evidence-based home visiting program (see page 13 for a description). EHS can also be provided in a center-based setting, although families enrolled in center-based EHS also receive at least two home visits per year.

EHS is primarily federally funded. In FFY 2019, there were 40 EHS grantee sites throughout Ohio offering home-based services in more than two-thirds (59) of Ohio counties. A total of 4,126 Ohio children were served through EHS home-based programs between Oct. 1, 2018 and Sept. 30, 2019.[24]

SafeCare Augmented
Since 2016, the YWCA of Greater Cincinnati has partnered with Hamilton County Job and Family Services and Every Child Succeeds on a home visiting program using the HomVEE-designated, evidence-based SafeCare Augmented model (see description on page 14). The program is available to Hamilton County families with children ages 0-5 in the child welfare system whose parents do not have active/untreated opioid addiction or mental health issues. The program is funded by the Hamilton County Department of Job and Family Services and served 90 households in FFY 2019.[25]

Home Instruction for Parents of Preschool Youngsters (HIPPY)
Funded by the United Way of Greater Cincinnati and private foundations, the Children's Home of Cincinnati has been operating a HIPPY program since June 2019 to improve school readiness (see page 13 for a description). The Children's Home of Cincinnati HIPPY program served 111 households in Brown (55), Clermont (18) and Hamilton (38) counties between July 1, 2018 and June 30, 2019.

Piqua Parents as Teachers
The Piqua PAT program is funded through grants from the United Way of Miami County and Piqua City Schools. The program served 80 households in Miami County in FFY 2019.

My Baby & Me Healthy Families America
In 2019, Ohio was one of five states to receive federal HRSA Healthy Start grant funding for its My Baby & Me program. The program is also funded through Columbus Public Health. The program began implementing the HFA model in July 2019, serving 10 households by the end of FFY 2019 (Sept. 30, 2019).

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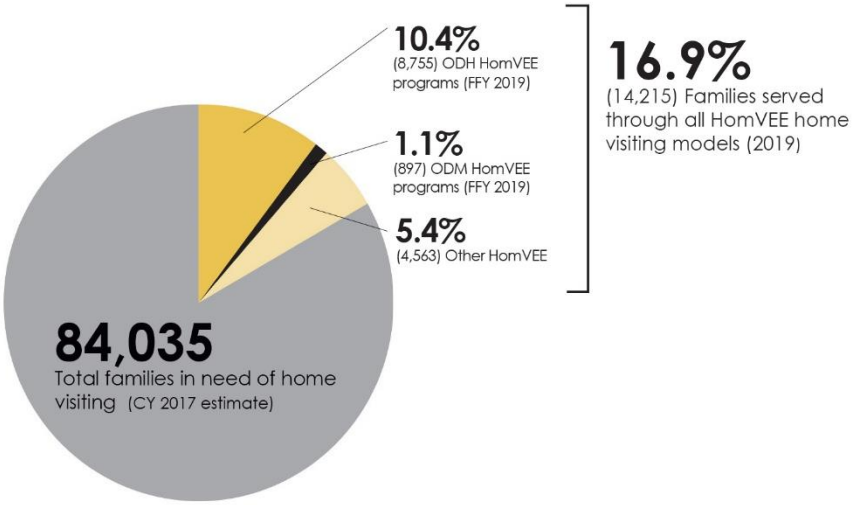
[23] Information provided by the Ohio Children's Trust Fund on April 1, 2020.
[24] Due to data availability, the number served includes counts of children served in 44 counties (2,968) and funded enrollment numbers for 15 counties (1,158). Information provided by the Ohio Head Start Collaboration Office via email on Apr. 29, 2020.
[25] Information provided by the YMCA of Greater Cincinnati on Aug. 12, 2019.

Other HomVEE programs households served and needs met analysis

The percent of need for home visiting services in Ohio met through other HomVEE programs is 5.4% (4,563 households). When combined with households served through ODH HMGHV HomVEE programs and ODM-funded HomVEE programs, there were a total of 14,215 households served (see figure 3.11). This represents 16.9% of the estimated number of Ohio families in need of home visiting services.

Figure 3.11. **Estimated percentage of need met through all HomVEE programs, 2019**



Source: Estimate of families in need of home visiting services derived from 2017 American Community Survey data provided by the Health Resources Services Administration; Number of families served data is from the Ohio Department of Health (FFY 2019), Ohio Children's Trust Fund (SFY 2019), the Ohio Head Start Collaboration Office (FFY 2019), YWCA of Greater Cincinnati (FFY 2019), the Children's Home of Cincinnati (July 2018-June 2019), Columbus Public Health (FFY 2019) and Piqua Parents as Teachers (FFY 2019)

Summary of reach and capacity assessment for all HomVEE programs

Figure 3.12 shows the reach of each HomVEE model operating in Ohio, as well as the percent of families in need of home visiting services served through each model. For context, funding sources for HomVEE programs are outlined in figure 3.2.

Figure 3.12. **Households served and needs met through all HomVEE programs in Ohio, 2019**

Home Visiting Model	Number of counties with contracted providers	Number of families served	Percent of families in need of home visiting served
Healthy Families America	70	7,544	9%
Early Head Start (Home-based option)	59	4,126*	4.9%
Parents as Teachers	18	826	1%
Nurse-Family Partnership	6	1,518	1.8%
HIPPY	3	111	0.1%
SafeCare Augmented	1	90	0.1%
Total for Ohio	**88**	**14,215**	**16.9%**

*Early Head Start total includes counts of children served in 44 counties (2,968) and funded enrollment numbers for 15 other counties (1,158)
Sources: Estimate of families in need of home visiting services derived from 2017 American Community Survey data provided by the Health Resources Services Administration; Number served data for HFA, NFP and PAT is from the Ohio Department of Health (FFY 2019), Ohio Children's Trust Fund (SFY 2019) Columbus Public Health (FFY 2019) and Piqua Parents as Teachers (FFY 2019). Early Head Start data is from the Ohio Head Start Collaboration Office (FFY 2019), SafeCare Augmented data is from the YWCA of Greater Cincinnati (FFY 2019) and HIPPY data is from the Children's Home of Cincinnati (July 2018-June 2019)

Figure 3.13 shows the percent of estimated need met through all HomVEE programs for each county. For a detailed table, see Appendix E. Fifty-nine of Ohio's 88 counties had

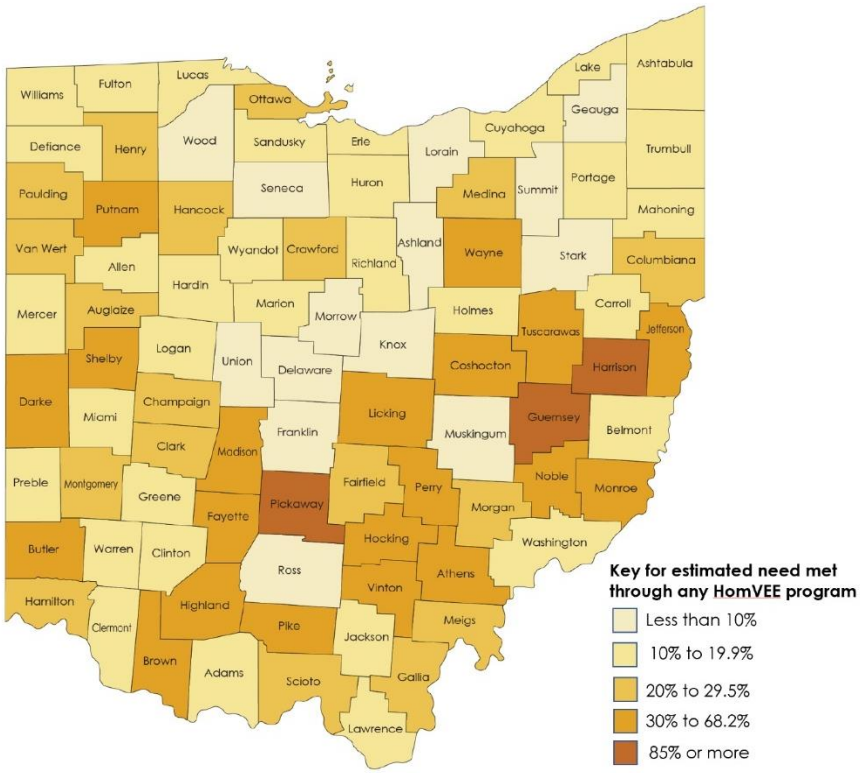
less than 25% of their estimated need met through all HomVEE programs. Thirty counties in Ohio had less than 15% of estimated need met.

When compared to the analysis of need met through only ODH-administered HMGHV HomVEE programs, there are several notable differences. First, the southeastern and southern central portions of the state have a considerably higher percent of estimated need met when all HomVEE programs are included. This is largely due to Early Head Start. For example:

- Lawrence County increased from 0% to 19.9%
- Athens County increased from 16.9% to 42.3%
- Guernsey County increased from 15.2% to 93.9%

The five counties with the greatest percentage point increases are all in the southeastern and southern central portions of the state (see figure 3.14).

Figure 3.13. **Estimated percentage of need met through all HomVEE programs, by county, 2019**



Source: Estimate of families in need of home visiting services derived from 2017 American Community Survey data provided by the Health resources Services Administration; Number of families served data is from the Ohio Department of Health (FFY 2019), Ohio Children's Trust Fund (SFY 2019), Ohio Head Start Collaboration Office (FFY 2019), YWCA of Greater Cincinnati (FFY 2019), the Children's Home of Cincinnati (July 2018-June 2019), Columbus Public Health (FFY 2019) and Piqua Parents as Teachers (FFY 2019).

Counties in the far northeastern corner of the state continued to have low percentages of estimated need met, even when households served through all HomVEE programs were included. For example, Geauga County remained at just 1% of need met and Stark County increased from 5.9% to 6.7%.

Figure 3.14. **Counties with the greatest percentage point increase in percent of estimated need met between only ODH-administered HomVEE programs and all HomVEE programs**

County	Percent of estimated need met through ODH-administered HomVEE programs	Percent of estimated need met through all HomVEE programs	Percentage point difference
Guernsey	15.2%	93.9%	78.7%
Pickaway	7.7%	85.9%	78.2%
Brown	10.4%	67.6%	57.2%
Monroe	6.5%	47.7%	41.2%
Noble	23.2%	57.4%	34.2%

Source: Estimate of families in need of home visiting services derived from 2017 American Community Survey data provided by the Health Resources Services Administration; Number of families served data is from the Ohio Department of Health (FFY 2019), Ohio Children's Trust Fund (SFY 2019), Columbus Public Health (FFY 2019), Piqua Parents as Teachers (FFY 2019), the Ohio Head Start Collaboration Office (FFY 2019), YWCA of Greater Cincinnati (FFY 2019) and the Children's Home of Cincinnati (July 2018-June 2019)

Estimated percentage of need met through all HomVEE programs for each ODH home visiting region is in Appendix E.

At-risk communities

A total of 8,776 households in the 27 at-risk communities were served through one of Ohio's HomVEE programs in 2019. This represents 16.5% of the estimated number of families in need of home visiting services in those counties (53,059 families). Only six of the 27 at-risk counties had less than 15% of estimated need met when all HomVEE programs were accounted for, compared to 13 counties when only accounting for households served through ODH HomVEE programs. Figure 3.15 shows the at-risk counties with the highest and lowest percentages of estimated need met through all HomVEE programs.

Figure 3.15. **At-risk communities with the highest and lowest percent of estimated need met through all HomVEE programs**

At-risk communities with the highest percent of estimated need met	At-risk communities with the lowest percent of estimated need met
Guernsey (93.9%)	Ross (6.8%)
Vinton (68.2%)	Franklin (7.2%)
Fayette (54.8%)	Muskingum (9%)
Pike (51.4%)	Summit (9.5%)
Coshocton (46.8%)	Cuyahoga (11.2%)

Source: Estimate of families in need of home visiting services derived from 2017 American Community Survey data provided by the Health Resources Services Administration; Number of families served data is from the Ohio Department of Health (FFY 2019), Ohio Children's Trust Fund (SFY 2019), Columbus Public Health (FFY 2019), Piqua Parents as Teachers (FFY 2019), the Ohio Head Start Collaboration Office (FFY 2019), YWCA of Greater Cincinnati (FFY 2019) and the Children's Home of Cincinnati (July 2018-June 2019)

Figure 3.16 shows the at-risk counties with the greatest percentage point increases in percent of need met from only ODH-administered HomVEE programs to all HomVEE programs.

Figure 3.16. **At-risk communities with the greatest percentage point increase in percent of estimated need met between only ODH-administered HomVEE programs and all HomVEE programs**

County	Percent of estimated need met through ODH-administered HomVEE programs	Percent of estimated need met through all HomVEE programs	Percentage point difference
Guernsey	15.2%	93.9%	78.7%
Athens	16.9%	42.3%	25.4%
Fayette	34.8%	54.8%	20%
Lawrence	0%	19.9%	19.9%
Highland	12.7%	31.1%	18.4%

Source: Estimate of families in need of home visiting services derived from 2017 American Community Survey data provided by the Health Resources Services Administration; Number of families served data is from the Ohio Department of Health (FFY 2019), Ohio Children's Trust Fund (SFY 2019), Columbus Public Health (FFY 2019), the Ohio Head Start Collaboration Office (FFY 2019), YWCA of Greater Cincinnati (FFY 2019) and the Children's Home of Cincinnati (July 2018-June 2019)

Non-HomVEE home visiting programs

There are various other programs operating throughout Ohio that provide home visiting services and related supports but are not HomVEE-designated programs. These programs serve many Ohio families, and sometimes provide additional support to pregnant women or families with young children who are also served through HomVEE models. As indicated on page 14, there may be overlap in the data for households served through HomVEE and other non-HomVEE home visiting models.

This section provides data and information on these additional non-HomVEE-designated home visiting programs:

- Moms and Babies First.
- Certified Pathways Community HUBs.
- SPARK.
- Healthy Start.

Home visiting services provided through private health insurers and Medicaid managed care organizations are also discussed.

Moms and Babies First

As part of HMGHV, ODH also administers Moms and Babies First programs. These are community health worker-implemented infant vitality programs to reduce Black infant mortality in areas of the state with high rates. Home visiting services and activities conducted vary by program, and there is no requirement for Moms and Babies First programs to use a HomVEE-designated home visiting model. A family cannot be enrolled in multiple ODH-funded and -supported programs at the same time, so a family cannot be served simultaneously by Moms and Babies First and another ODH-administered HMGHV program.

Moms and Babies First programs serve pregnant African-American/Black women with incomes at or below 200% FPL that have either experienced a previous poor birth outcome or meet at least one of a list of additional risk factors.[26]

These programs are funded with federal Maternal and Child Health (MCH) block grant and state GRF dollars. Providers receive approximately $2,000 from ODH for each family served. In FFY 2019, there were 13 ODH-contracted Moms and Babies First providers, serving 14 counties (Allen, Butler, Clark, Cuyahoga, Franklin, Hamilton, Lorain, Lucas, Mahoning, Montgomery, Richland, Stark, Summit and Trumbull).[27] Several Moms and Babies First programs also receive Ohio Medicaid funding to increase program capacity and serve more women.

A total of 1,620 households were served in FFY 2019 with funding through ODH (1,168) and ODM (452).

Help Me Grow (HMG) Early Intervention (Part C)

The HMG Early Intervention (EI) program provides services to families with eligible children under age 3 with developmental disabilities or delays. The program is administered by the Department of Developmental Disabilities and fulfills the requirements of Part C of the federal *Individuals with Disabilities Education Act (IDEA)*. Over 23,400 children were served through HMG EI in SFY 2019.[28]

HMG EI is not considered a home visiting program in Ohio; however, services are commonly provided inside the family's home. Parents and families are coached by an EI provider on how to help their child learn and develop.

The program is available statewide and is funded through a combination of state GRF dollars, local funds from county boards of developmental disabilities and federal funding from the U.S. Department of Education.

Certified Pathways Community HUBs

The certified Pathways Community HUB model (HUB) is a community care coordination program that utilizes community health workers (CHWs) to identify women at risk of having poor birth outcomes, connect them to medical and social services and track risk factors.

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[26] Women must possess at least one of the social determinants of health risk factors as defined by the Centers for Disease Control and Prevention. These include, but are not limited to: under age 21, first-time pregnancy at age 35 or older, unplanned pregnancy, diagnosed medical condition (diabetes, hypertension, short cervix, etc.), substance abuse or demonstrate a need for substance abuse treatment, users of tobacco products in the home, unstable housing or homelessness, or depression or other diagnosed mental health concern. Eligibility information provided by the Ohio Department of Health on July 22, 2019.

[27] Data provided by the Ohio Department of Health on Mar. 3, 2020.

[28] Ohio Department of Developmental Disabilities. *Annual Report Fiscal Year 2019*. Accessed Apr. 1, 2020. https://dodd.ohio.gov/wps/wcm/connect/gov/d147cee7-aa7a-4fb5-9b51-bf87685ef78f/2019+DODD+Annual+Report+-+for+Web.pdf?MOD=AJPERES&CONVERT_TO=url&CACHEID=ROOTWORKSPACE.Z18_M1HGGIK0N0JO00QO9DDDDM3000-d147cee7-aa7a-4fb5-9b51-bf87685ef78f-mYlmrqn

In this model, CHWs assess clinical, social, economic and behavioral risk factors and work with clients through home visits and community referrals to address these issues.[29] Studies have shown that participation in the model was associated with improved birth outcomes.[30] The HUB model is designated as a best practice by the Association of Maternal and Child Health Programs.[31]

Figure 3.17. **Ohio Commission on Minority Health (OCMH)-funded HUBs, SFY 2020-2021**

HUB	Geographic coverage area	Number of households served**
Community Health Access Project (CHAP)*	Richland, Ashland, Crawford, Huron, Knox and Morrow Counties	527 (FFY 2019)
Northwest Ohio Pathways HUB*	Lucas, Wood, Fulton, Henry, Sandusky and Erie Counties	1,180 (FFY 2019)
Health Care Access Now (HCAN)*	Hamilton, Clermont, Warren and Butler Counties	675 (FFY 2019)
Pathways HUB Community Action*	Summit County	1,842 (CY 2019)
Mahoning Valley Pathways HUB*	Mahoning and Trumbull Counties	559 (FFY 2019)
Central Ohio Pathways HUB*	Franklin, Union, Delaware, Licking, Madison, Pickaway and Fairfield Counties	223 (3/1/2019-9/30/2019)
Community Action Pathways HUB	Stark County	99 (FFY 2019)
Better Health Pathways HUB (Officially launched Feb. 27. 2020)	Cuyahoga County	0
Bridges to Wellness HUB	Tuscarawas, Carroll, Coshocton, Guernsey and Muskingum Counties	35 (FFY 2019)
Dayton Regional Pathways HUB (Will launch in 2020)	Montgomery County	0

*HUB is certified through the **Pathways Community HUB Institute**
**Counts of households served include pregnant women and families with young children
Note: There is an 11th HUB in Ohio (Stark County THRIVE Pathways HUB) that also serves Stark County, is not yet certified and is not receiving funding from OCMH in SFY 2020-2021. The HUB served 343 households in FFY 2019.
Source: Information provided by each individual HUB

There are six certified HUBs and five HUBs that are not yet certified operating in Ohio. All six certified HUBs and four of the five uncertified HUBs received funding from the Ohio Commission on Minority Health (OCMH) in SFY 2020-2021 (see figure 3.17). ODM also

[29] "Pathways Community HUB Model Overview." PCHI. Accessed July 22, 2019. https://pchi-hub.com/hubmodeloverview

[30] Redding, Sarah, et al. "Pathways Community Care Coordination in Low Birth Weight Prevention." *Maternal and Child Health Journal* 19 (2015):643–650. doi: 10.1007/s10995-014-1554-4 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4326650/pdf/10995_2014_Article_1554.pdf. See also Lucas, Brad and Amber Detty. "Improved Birth Outcomes through Health Plan and Community Hub Partnership." *Obstetrics & Gynecology* Vol. 133 (2018): 133S. doi: 10.1097/01.AOG/01.AOG.0000559252.69867.6d

[31] Innovation Station. *Innovation Station Practice Summary and Implementation Guidance: Pathways Community HUB*. Accessed July 22, 2019. http://www.amchp.org/programsandtopics/BestPractices/InnovationStation/ISDocs/Pathways%20Community%20HUB.pdf

provides funding to support community health workers in several of the HUBs.[32] Sources of funding vary by HUB and may include local governments, the federal government, private philanthropy and reimbursement through contracts with Ohio's Medicaid managed care organizations.

Supporting Partnerships to Assure Ready Kids (SPARK)

SPARK is a family-focused, kindergarten readiness program for 3- and 4-year-old children. Home visitors work to increase parent engagement and strengthen the learning advocacy role of parents. SPARK also conducts developmental screenings, provides referrals and linkages to community resources and offers group-based learning opportunities. Program evaluations have shown that SPARK children score significantly higher on kindergarten readiness literary assessments.[33] As of June 2020, SPARK does not have a HomVEE designation; however, evidence of SPARK's effectiveness was recently submitted to HomVEE for review.

There are ten SPARK sites throughout Ohio as of June 2020, and a total of 3,119 children were served in the 2019 and 2020 SPARK cohorts.[34] A majority of the families served through SPARK have household incomes at or below 200% FPL and receive public assistance.[35] Funding sources differ by SPARK site, but program funding primarily comes from local public and private sources.

Healthy Start

HRSA's Healthy Start program aims to reduce disparities in maternal and infant health status in high-risk communities. Grantees work to reduce infant mortality rates, increase access to early prenatal care and remove barriers to healthcare access, which often includes the provision of home visiting services. In 2019, HRSA awarded funding to five Healthy Start sites in Ohio (see figure 3.18).[36] Healthy Start programs are not required to use a HomVEE-designated evidence-based home visiting model.[37]

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[32] Information provided by the Ohio Department of Medicaid on May 13, 2019.
[33] Kenne, Deric R., et al. "Economic Disparities: SPARK Ohio and Narrowing the Kindergarten Readiness Gap." *Child Development Research* (2018). https://doi.org/10.1155/2018/4383792; See also Fischbein, Rebecca, et al. "SPARK Ohio: An Early Childhood Intervention Program Description and Evaluation." *The International Journal of Early Childhood Learning* 23, Issue 4 (2016). doi:10.18848/2327-7939/CGP
[34] See note 7.
[35] Information provided by the Early Childhood Resource Center on May 7, 2019. "SPARK Ohio: A program of the Early Childhood Resource Center".
[36] "2019 Healthy Start Grant Awardees." Health Resources and Services Administration. Accessed July 22, 2019. https://mchb.hrsa.gov/maternal-child-health-initiatives/healthy-start/awards
[37] "Effectiveness Research." U.S. Department of Health and Human Services Home Visiting Evidence of Effectiveness. Accessed August 28, 2019. https://homvee.acf.hhs.gov/

Figure 3.18. **Healthy Start awardees in Ohio, 2019**

Grantee	County	Number of households served*
City of Cleveland – Moms First program	Cuyahoga	1,123 (CY 2019)
City of Columbus – My Baby & Me program**	Franklin	815 (FFY 2019)
Lucas County – Healthy Start program	Lucas	1,300 (CY 2019)
Cincinnati Children's Medical Center	Hamilton	689 (FFY 2019)
Five Rivers Health Centers	Montgomery	492 (CY 2019)

*Counts of households served include pregnant women and families with young children
Source: Grantee list provided by the Health Resources and Services Administration. Numbers served provided by each Healthy Start site.

Home visiting through Medicaid managed care organizations (MCOs)

As of January 2019, 85% of Ohio Medicaid enrollees were enrolled in Medicaid managed care.[38] MCOs provide care management services to their members when necessary, and in some cases, this may involve home visiting.

Some MCOs partner with HMGHV programs and others employ staff to provide home visiting services.[39] All five MCOs[40] are required by state law to contract with Certified Pathways Community HUBs for home visits provided by community health workers.[41]

Home visiting through private health insurers

Some private health insurance companies provide home visiting services to their members. For example, some health plans offer one home visit to their members for each new child born. Nurses or other healthcare workers may conduct these home visits. Health plan home visiting structures, models and benefits vary by insurer.

There is no publicly available source for tracking which health insurers provide home visiting services to their members.

Non-HomVEE home visiting programs households served analysis

Figure 3.19 shows the reach of the non-HomVEE programs for which data is available.

[38] Health Policy Institute of Ohio. "Ohio Medicaid Basics 2019," April 2019.
[39] Information provided by the Ohio Department of Medicaid in person on May 13, 2019.
[40] UnitedHealthcare Community Plan, Buckeye Health Plan, CareSource, Paramount Advantage and Molina Healthcare
[41] ORC § 5167.173

Figure 3.19. **Available data on counties and households served by non-HomVEE home visiting programs operating in Ohio, 2019**

Home visiting program	Number of counties served	Number of households served
Moms and Babies First programs	Thirteen providers serving 14 counties in FFY 2019 (Allen, Butler, Clark, Franklin, Richland, Hamilton, Lorain, Lucas, Mahoning, Montgomery, Cuyahoga, Stark, Summit and Trumbull)	1,620 (FFY 2019)
Pathways Community HUBs	Eleven HUBs serving a total of 34 counties (as of June 2020)	5,483 (FFY 2019 and CY 2019)
Supporting Partnerships to Assure Ready Kids (SPARK)	Programs in 10 counties (Ashland, Butler, Clark, Cuyahoga, Darke, Franklin, Hamilton, Mahoning, Stark and Summit) as of June 2020	3,119 (2019 and 2020 SPARK cohorts)
Healthy Start	Five federal grant awardees in 2019 (Cuyahoga, Franklin, Hamilton, Lucas and Montgomery Counties)	4,419 (FFY 2019 and CY 2019)

Sources: Pathways Community HUB data provided by Northwest Ohio Pathways HUB (FFY 2019), Mahoning Valley Pathways HUB (FFY 2019), Stark County THRIVE Pathways HUB (FFY 2019), Central Ohio Pathways HUB (3/1/19-9/30/19), Bridges to Wellness HUB (FFY 2019), Community Action Pathways HUB (FFY 2019), Pathways HUB Community Action (CY 2019), Health Care Access Now (FFY 2019), Community Health Access Project (FFY 2019). Moms & Babies First data provided by the Ohio Department of Health (FFY 2019). SPARK data provided by SPARK Ohio (2019 and 2020 SPARK Cohorts). Healthy Start data provided by MomsFirst (CY 2019), Columbus Public Health (FFY 2019), Toledo-Lucas County Health Department (CY 2019). Cradle Cincinnati (FFY 2019) and Five Rivers Health Center (CY 2019).

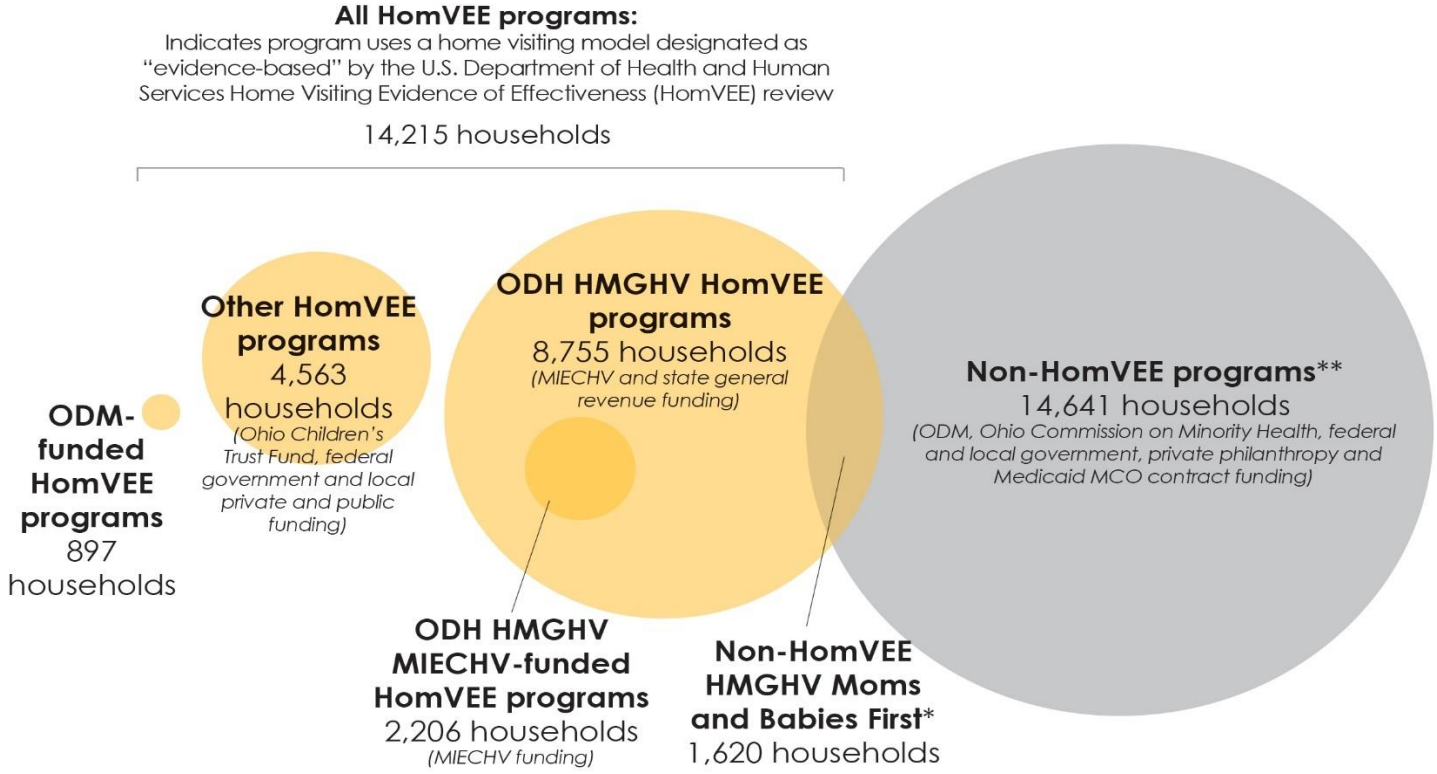
Summary of all home visiting programs in Ohio

Figure 3.20 provides a diagram of all home visiting programs in Ohio. The diagram demonstrates the complexity of Ohio's home visiting landscape, highlighting the state's multiple home visiting programs and funding streams.

Appendix E includes a table of all home visiting models and programs operating in Ohio's 27 at-risk communities.

Figure 3.20 **Ohio's home visiting landscape**

Acronym Key
ODH HMGHV HomVEE: Ohio Department of Health (ODH) Help Me Grow Home Visiting (HMGHV) HomVEE programs
MIECHV-funded ODH HMGHV HomVEE: ODH HMGHV HomVEE programs
ODM-funded HomVEE: Ohio Department of Medicaid (ODM)-funded HomVEE programs.
Other HomVEE programs: Programs include Early Head Start Home-Based Option, SafeCare Augmented, HIPPY, My Baby & Me, Healthy Families America (HFA), Piqua Parents as Teachers (PAT) and HFA and PAT programs funded by the Ohio Children's Trust Fund.
Non-HomVEE programs: Programs include Moms and Babies First, Pathways Community HUBS (certified and non-certified), SPARK, Healthy Start and home visiting services provided through private health insurers and Medicaid managed care organizations (MCOs).



*As part of HMGHV, ODH also administers Moms and Babies First programs that are not required to implement HomVEE-designated models. The 1,620 count includes households served with funding from ODH and ODM.
**May include households also served through a HomVEE program.
Source: Number of households served data for HomVEE programs provided by the Ohio Department of Health (FFY 2019), Ohio Children's Trust Fund (SFY 2019), Columbus Public Health (FFY 2019), Ohio Head Start Collaboration Office (FFY 2019), YWCA of Greater Cincinnati (FFY 2019) and the Children's Home of Cincinnati (July 2018-June 2019). Pathways Community HUB data provided by Northwest Ohio Pathways HUB (FFY 2019), Mahoning Valley Pathways HUB (FFY 2019), Stark County THRIVE Pathways HUB (FFY 2019), Central Ohio Pathways HUB (3/1/19-9/30/19), Bridges to Wellness HUB (FFY 2019), Community Action Pathways HUB (FFY 2019), Pathways HUB Community Action (CY 2019), Health Care Access Now (FFY 2019), Community Health Access Project (FFY 2019). Moms & Babies First data provided by the Ohio Department of Health (FFY 2019). SPARK data provided by SPARK Ohio (2019 and 2020 SPARK Cohorts). Healthy Start data provided by MomsFirst (CY 2019), Columbus Public Health (FFY 2019), Toledo-Lucas County Health Department (CY 2019), Cradle Cincinnati (FFY 2019) and Five Rivers Health Center (CY 2019).

Additional information on home visiting capacity and quality in Ohio

This section provides additional information and analysis of home visiting capacity and quality using the following sources:

- Key findings from the Ohio Home Visiting Provider Capacity and Readiness Assessment Online Survey ("Online Survey").
- Findings from key informant interviews.
- Waitlist data for ODH-administered home visiting programs.
- State-level initiatives related to home visiting and early childhood system improvements.

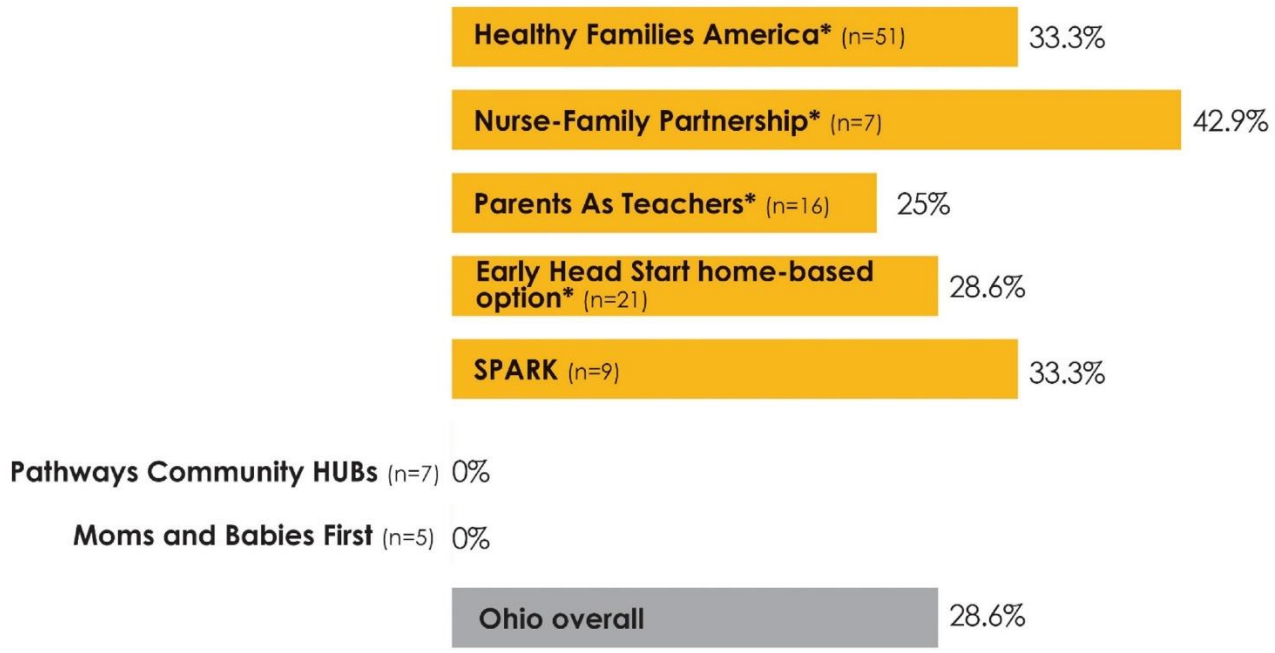
Review of online survey and key informant interview findings on home visiting capacity and quality

For additional information on the online survey process and respondents, as well as key informant interviews, see Appendix D. A copy of the online survey is in Appendix F.

Home visiting provider waitlists

Online survey respondents were asked how often their home visiting program(s) had a waitlist. Half (50%) of respondents reported "rarely" or "never" having a waitlist, 21% said "sometimes" and 28.6% said either "very often" or "always" (see figure G.1 in Appendix G). When looking across home visiting models and programs, Nurse-Family Partnership was the model with the highest percentage of programs (43%) reporting "very often" or "always" having a waitlist (see figure 3.21).

Figure 3.21. **Very often or always have a waitlist, by home visiting model/program**



*Indicates an evidence-based home visiting model based on the Department of Health and Human Services (HHS) Home Visiting Evidence of Effectiveness (HomVEE) list

Note: Models or programs with less than five respondents are not shown: HIPPY (1), SafeCare Augmented (2), Healthy Start sites (3)

Source: HPIO analysis of Ohio Home Visiting Provider Capacity and Readiness Assessment Online Survey, May 2020

Waitlist information on ODH-administered and ODM-funded home visiting programs can be found in Appendix G.

Barriers to capacity

Online survey respondents were asked to identify the largest barriers impacting their ability to serve all pregnant women and families eligible for and requesting home visiting services. The top ten responses, as well as the percentage of survey respondents who identified the barrier, are shown in figure 3.22.

Figure 3.22. **Top ten responses to, "What are the largest barriers impacting your ability to serve all pregnant women/families eligible for and requesting home visiting services?"** (N=99)

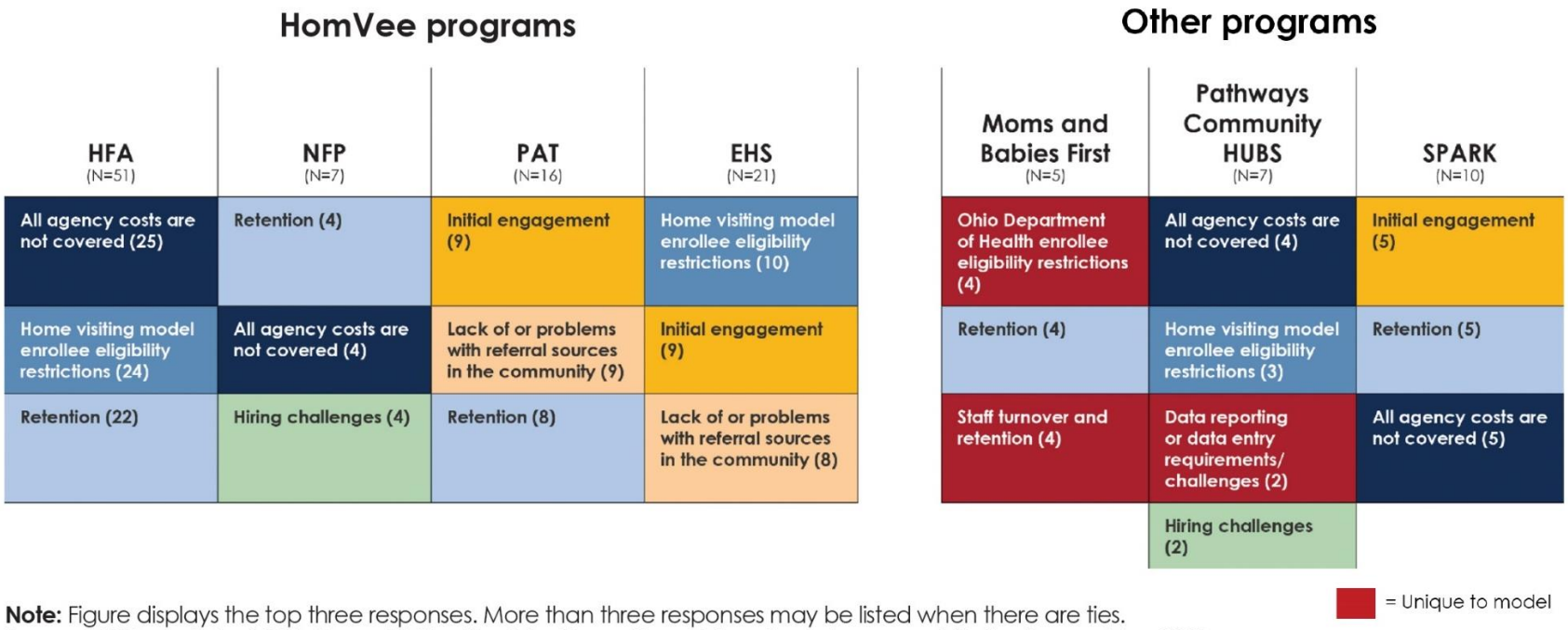
Response	Percent
Retention (i.e., challenges with families not continuing with the program)	**44.4%**
Initial engagement (i.e., identifying families in need, combating negative perceptions associated with home visiting)	**41.4%**
Funding: All agency costs are not covered	**41.4%**
Home visiting model enrollee eligibility restrictions	**39.4%**
Hiring challenges (i.e., unable to find qualified home visiting staff)	**34.3%**
Lack of or problems with referral sources in the community	33.3%
Data reporting or data entry requirements/challenges (e.g., Ohio Comprehensive Integrated Home Visiting Data System double entry, obligations to report data to the State or others)	28.3%
Pregnant women/families not following up when referred to other services and supports	27.3%
Challenges related to Central Intake referrals	25.3%
Ohio Department of Health enrollee eligibility restrictions	23.2%

Source: HPIO analysis of Ohio Home Visiting Provider Capacity and Readiness Assessment Online Survey, May 2020

The two most-commonly selected barriers to providing home visiting services were related to retaining families in a home visiting program and initial engagement of families. Survey respondents also commonly identified a lack of adequate funding as a top barrier, as well as eligibility restrictions of specific home visiting models or programs and hiring challenges.

Figure 3.23 shows the top barriers identified by home visiting model or program. There was no barrier that appeared in the top three across all models and programs. Retention was identified as a top-three barrier for five of the seven (all except Early Head Start and Pathways Community HUBs). Inadequate funding appeared for four of the seven.

Figure 3.23. **Top three responses to, "What are the largest barriers impacting your ability to serve all pregnant women/families eligible for and requesting home visiting services?" by home visiting model or program**



Note: Figure displays the top three responses. More than three responses may be listed when there are ties.
Source: HPIO analysis of Ohio Home Visiting Provider Capacity and Readiness Assessment Online Survey, May 2020

Barriers and challenges identified by key informants
Many top barriers identified by online survey respondents were also highlighted by key informants. For example, many key informants discussed the challenges of initial engagement and retention, noting the large amount of resources necessary for identifying, reaching out to and maintaining relationships with families. Key informants also explained that families are often initially resistant to accepting services, often due to unfavorable perceptions of home visiting or discomfort with having a stranger in their home.

Also consistent with survey findings was a unique challenge identified by a key informant who represented a HMGHV provider organization serving an Appalachian county. She explained that educational requirements often make it difficult to fill home visitor positions since it is less common for individuals in that area of the state to have the necessary levels of educational attainment.

Barriers to capacity by county type can be found in Appendix G.

Staffing challenges
Survey respondents were asked about experiences with hiring and staff turnover. When asked how often they have trouble finding and hiring qualified staff for home visiting positions, a total of 27.3% of survey respondents reported that they "always" or "usually" have trouble, 40.4% reported that they sometimes have trouble and 32.4% reported "rarely" or "never" having trouble (see figure G.5 in Appendix G).

All the respondents that reported sometimes, usually or always having trouble hiring staff were then asked to identify the top three reasons why they faced challenges (see figure 3.24). The three most common responses were:
- Compensation is too low to attract desirable candidates.
- Candidates lack required experience or degrees.
- Candidates lacked the necessary knowledge and skills.

For an analysis of the top three reasons for hiring challenges by home visiting region, see figure G.6 in Appendix G.

Figure 3.24. **Top reasons for hiring trouble** (N=64)

Response	Percent
Compensation is too low to attract desirable candidates	**75.0%**
Candidates lack required experience or degrees	**73.4%**
Candidates lack necessary knowledge and skills	**40.6%**
Barriers associated with training (e.g., availability and costs of trainings and costs associated with hiring staff and not being able to get them trained right away)	20.3%
Candidates are not culturally competent	7.8%
Lack of understanding of role or recognition of role's value	3.1%
Lack of applicants that apply	1.6%
Upfront costs of hiring	1.6%
Lack of upward mobility	1.6%
Limited use of degree	1.6%
Uncertainty of positions due to uncertainty of funding	1.6%

Source: HPIO analysis of Ohio Home Visiting Provider Capacity and Readiness Assessment Online Survey, May 2020

A smaller percentage of respondents reported challenges with staff turnover and retention. Only 12.4% of programs reported "always" or "very often" experiencing trouble with staff turnover and retention, 35.1% reported "sometimes" having trouble and more than half (52.6%) reported "rarely" or "never" having trouble (see figure G.7 in Appendix G).

Respondents who reported that they "sometimes", "very often" or "always" experience challenges with staff turnover and retention were asked to explain why (see figure 3.25). The most common reason given was compensation. Stress and burnout were also commonly mentioned. Other top-five responses included administrative burdens, career or professional advancement and competing family or personal priorities (i.e., working inconvenient or unconventional hours).

Figure 3.25. **Top reasons for staff turnover challenges** (N=46)

Response	Percent
Compensation/employment benefits	**58.7%**
Burnout/stress	**28.3%**
Administrative burdens/barriers (e.g., model fidelity, reporting and paperwork requirements, policy changes)	**15.2%**
Career/professional advancement	**15.2%**
Competing family/personal priorities	**13.0%**
Job transition within organization	10.9%
Safety issues/second victim phenomenon	8.7%
Lack of skills, credentials and/or competencies needed	8.7%
Supervisory issues	4.3%
No specific reason/issue identified	8.7%

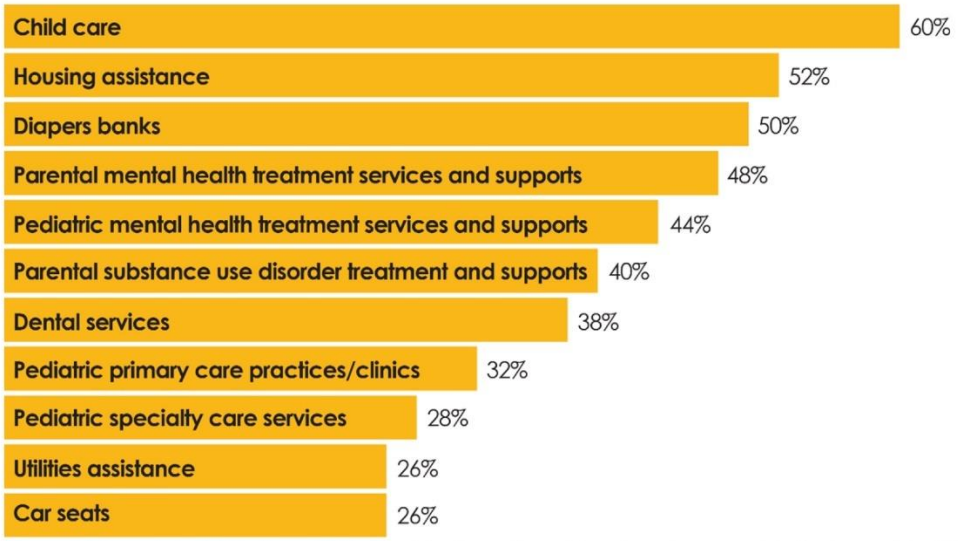
Source: HPIO analysis of Ohio Home Visiting Provider Capacity and Readiness Assessment Online Survey, May 2020

Community resources

To assess the extent to which community resources are available to support families in need, survey respondents were asked whether there were adequate health and social services and family supports available and accessible to pregnant women and families with young children in need of those services. Nearly half of the 97 respondents said "yes" (48.5%), 43.3% responded "somewhat' and 8.3% said "no".

Those who responded "somewhat" or "no" were asked to identify areas with the largest gaps in services and supports. Figure 3.26 provides the top-ten responses. Fifty percent or more of respondents identified childcare, housing assistance and diaper banks. Both parental and pediatric mental health treatment and services and supports were also among top-five responses.

Figure 3.26. **Top ten responses to, "You responded with 'no' or 'somewhat' to the previous question. Please indicate where the largest/most important gaps in services exist."** (N=50)



Source: HPIO analysis of Ohio Home Visiting Provider Capacity and Readiness Assessment Online Survey, May 2020

Collaboration

Survey respondents assessed the extent of collaboration both among home visiting programs and between home visiting programs and early childhood education programs.

Figure 3.27 provides responses describing the extent of collaboration among home visiting programs in a county. About a quarter of respondents indicated that home visiting programs in their county made or shared referrals and/or provided transition support to one another (25.3%) or that there was strong collaboration/coordination in their county (24.2%). In contrast, some respondents noted a lack of collaboration (14.7%). Other top responses included having regular communication and/or meetings (14.7%) and sharing services trainings, resources and/or space (13.7%).

Figure 3.27. **"Describe the extent of collaboration among home visiting programs in your county."** (N=95)

Response	Percent
Make or share referrals and/or transition support	**37.9%**
Strong collaboration/coordination	**28.4%**
Lack of collaboration/coordination	**18.9%**
Participation in a joint committee, council, collaborative or other initiative	**13.7%**
Shared services, trainings, resources and/or space	**11.6%**
Room for improvement	9.5%
Regular communication/meetings	7.4%
Ad hoc participation in meetings/trainings	6.3%
Shared or inter-agency plans/agreements	4.2%
Not applicable	4.2%
No response	4.2%
Lack of referrals	3.2%
Competitive	3.2%
Lack of data sharing infrastructure	1.1%

Source: HPIO analysis of Ohio Home Visiting Provider Capacity and Readiness Assessment Online Survey, May 2020

Figure 3.28 shows responses describing the extent of collaboration among home visiting programs and other early childhood programs in a county. Making or sharing referrals and transition support was the top response (37.9%). Twenty-eight percent (28.4%) of respondents indicated that there was strong collaboration in their county among home visiting and early childhood programs. In contrast, 18.9% indicated lack of collaboration.

Collaboration in the form of participation in a joint committee, council or other initiative (13.7%) and sharing services, trainings, resources and/or space (11.6%) were also among top responses.

Figure 3.28. **"Describe the extent of collaboration between home visiting programs and other early childhood programs in your county."** (N=95)

Response	Percent
Make or share referrals and/or transition support	**37.9%**
Strong collaboration/coordination	**28.4%**
Lack of collaboration/coordination	**18.9%**
Participation in a joint committee, council, collaborative or other initiative	**13.7%**
Shared services, trainings, resources and/or space	**11.6%**
Room for improvement	9.5%
Regular communication/meetings	7.4%
Ad hoc participation in meetings/trainings	6.3%
Shared or inter-agency plans/agreements	4.2%
Not applicable	4.2%
No response	4.2%
Lack of referrals	3.2%
Competitive	3.2%
Lack of data sharing infrastructure	1.1%
Other	1.1%

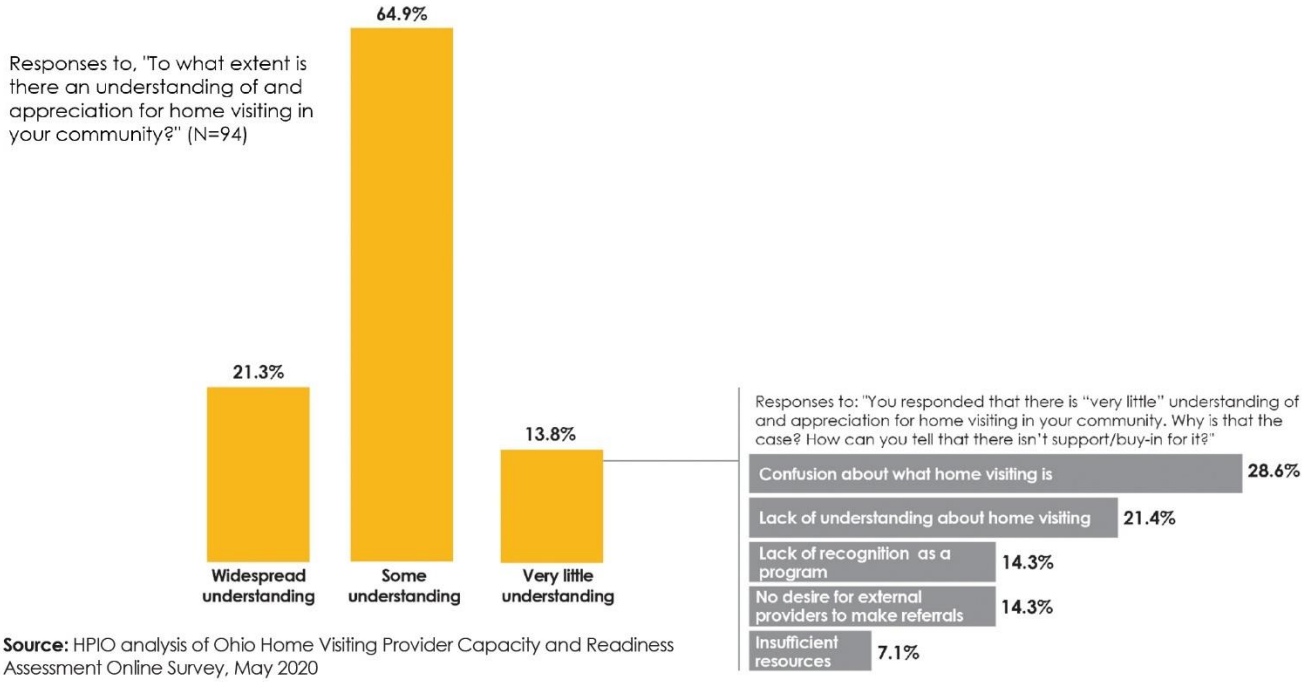
Source: HPIO analysis of Ohio Home Visiting Provider Capacity and Readiness Assessment Online Survey, May 2020

Understanding and appreciation of home visiting

To measure community engagement with home visiting, survey respondents were asked to assess the level of understanding and appreciation of home visiting in their county. Most respondents said there is "some" understanding/appreciation (64.9%), 21.3% said there is "widespread" understanding/appreciation, and 13.8% said there is "very little" understanding/appreciation.

Of those who said there is "very little" understanding and appreciation of home visiting in their county, confusion and lack of understanding about what home visiting is were the primary reasons cited (see figure 3.29).

Figure 3.29. **"To what extent is there an understanding of and appreciation for home visiting in your community?"** (N=94)



Source: HPIO analysis of Ohio Home Visiting Provider Capacity and Readiness Assessment Online Survey, May 2020

Opportunities for system improvement

Key informants were asked how home visiting could be better coordinated and/or administered at the state level. The top recommendations for improving state-level coordination and administration of home visiting were having a shared and comprehensive system for referrals to home visiting, enhanced coordination among state agencies such as ODH, ODM and DODD, improved data sharing and changes to ODH's funding/reimbursement models.

Similarly, online survey respondents were asked how state agencies could work more effectively and efficiently together to support home visiting in the state. Top responses included promoting common goals between home visiting programs and partners, increasing automatic referrals to home visiting from child protective services, WIC and Medicaid and increasing public education/awareness of home visiting.

Other top survey responses aligned directly with key informant feedback, including increased funding for home visiting, promoting a unified home visiting approach, including common definitions of home visiting, as well as increasing coordination of state-level meetings and communication across state agency and other local-level partners.

For additional information on recommendations provided by key informants and online survey respondents, see figures G.8 and G.9 in Appendix G.

State-level home visiting and early childhood system initiatives, including performance and data tracking

Governor's Advisory Committee on Home Visitation

Home visiting has received considerable support at the state level over the past year and a half. Expanding home visiting is a priority for Ohio's Governor, Mike DeWine. On his first full day in office, January 15, 2019, he created the Governor's Advisory Committee on Home Visitation and charged the committee with developing recommendations for achieving his goal of tripling the number of Ohio families served through evidence-based home visiting services.

The committee's final report (released in March 2019) includes 20 recommendations to achieve the Governor's vision. The report outlines ways to enhance quality of home visiting services in Ohio with recommendations for:

- Eliminating disparities.
- Engaging and enrolling families.
- Improving programming.
- Paying for home visiting services.
- Bolstering the home visiting workforce.

The Governor's support led to increased funding for home visiting services. The SFY 2020-2021 state operating budget, adopted by the Ohio General Assembly and signed into law by the Governor, included a total appropriation of $69,581,430 for the Help Me Grow home visiting program — an increase of approximately $30 million (74%) over the previous biennium.

Governor's Office of Children's Initiative

On January 14, 2019, by executive order, Governor DeWine created the Governor's Office of Children's Initiatives, "to elevate the importance of children's programming and drive improvements within the many state programs that serve children."[42] The charge of the Initiative is to:

1. Improve communication and coordination across all state agencies that provide services to Ohio's children.
2. Engage local, federal, and private sector partners to align efforts and investments in order to have the largest possible impact on improving outcomes for all of Ohio's children.
3. Advance policy related to home visiting, early intervention services, early childhood education, foster care, and child physical and mental health.
4. Initiate and guide enhancements to the early childhood, home visiting, foster care, education, and pediatric health systems.

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[42] Gov. Mike DeWine. "Executive Order 2019-02D: Creating the Governor's Children's Initiative." Accessed May 11, 2020. https://governor.ohio.gov/wps/portal/gov/governor/media/executive-orders/2019-02d. This applies to the following state agencies: the Ohio Department of Education, Ohio Department of Developmental Disabilities, Ohio Department of Job and Family Services, Ohio Department of Health, Ohio Department of Higher Education, Ohio Department of Medicaid, Ohio Department of Mental Health and Addiction Services, Ohio Department of Public Safety, Ohio Department of Youth Services and the Ohio Office of Budget and Management.

Priorities for the Governor's Office of Children's Initiatives include:

- Triple the number of families served by evidence-based home visiting.
- Ensure expanded access to high-quality childcare settings for all children.
- Prevention education in every grade, every year.
- All children have access to a mental health professional in their school.
- Reform the foster care system.
- Improve supports for families with multi-system youth.
- Reduce the incidence of Neonatal Abstinence Syndrome and substance-exposed infants.

Early Childhood Strategic Plan

A state team including the Governor's Office of Children's Initiatives is working on revising Ohio's Bold Beginning Early Childhood Strategic Plan, which was first developed in 2016-2017 with leadership from the office of former Governor John Kasich. The current vision of the strategic plan is: "Each child will engage in quality early learning and healthy development experiences that prepare that child for school and build a solid foundation for lifelong success." Looking across early childhood (birth-five) programs of the six child-serving state agencies, the plan is focused on quality improvement of early childhood programs and enhancing collaboration and coordination.

The state team includes representatives from the Ohio Departments of Health, Medicaid, Education, Job and Family Services, Mental Health and Addiction Services, and Developmental Disabilities. The team is working with the BUILD Initiative and redefining goals, strategies and measures for the plan.

Several other state-level initiatives which have relevance to home visiting are described in Appendix H:

- **Family First Prevention Services Act (FFPSA) planning**: The goal of this federal legislation was to keep children out of foster care. Ohio has preliminarily selected several HomVEE home visiting models as preventative services eligible for funding under FFPSA.
- **Ohio Department of Medicaid's Comprehensive Maternal and Infant Support Program**: One component will be Medicaid reimbursement for nurse home visiting services.
- **Office of Children's Services Transformation**: This work could impact home visiting because many children involved in the child welfare system could benefit from home visiting.

Ohio Comprehensive Home Visiting Integrated Data System (OCHIDS)

OCHIDS, launched by the Ohio Department of Health in July 2018, supports comprehensive data collection, monitoring, billing and electronic medical records. It is currently utilized by all ODH-administered home visiting program providers, as well as by the Medicaid-funded Ohio Equity Institute (OEI) community-based home visiting programs.

The Governor's Advisory Committee on Home Visitation recommended that all home visiting programs in the state use OCHIDS, which would expand utilization to Healthy Families America (HFA) and Parents as Teachers (PAT) programs funded by the Ohio Children's Trust Fund (OCTF), Early Head Start (EHS), Pathways Community HUBs and other programs operating in Ohio.

There are six benchmark domains and 22 performance metrics tracked in OCHIDS (see Appendix H). These metrics align with the 19 MIECHV performance measures.[43] In addition to the performance metrics tracked in OCHIDS, home visitors collect data on:

- Demographics.
- Housing status.
- Economic characteristics.
- Maternal and child health including indicators of healthcare access.
- Social-emotional needs.

Data tracking and reporting challenges

It is difficult to compare the performance of home visiting programs utilizing OCHIDS with other programs operating in the state because there is not an agreed-upon set of program quality and outcome measures. Challenges related to tracking data and performance across Ohio's home visiting programs include:[44]

- **Lack of disaggregated data to eliminate disparities.** Some demographic data, such as race and ethnicity, is compiled for home visiting programs utilizing OCHIDS. However, there is not standardized reporting of complete demographic data across all home visiting programs operating in the state (i.e., race and ethnicity, primary language, country of origin, etc.). This limits the state and other home visiting partners' ability to measure outcomes of home visiting interventions on at-risk populations for the purposes of eliminating disparities and advancing equity.
- **Inconsistent definitions**. There are no consistent definitions across Ohio's home visiting programs to track key performance measures. For example, the definition used to calculate the total number of households or Ohioans "served" by home visiting programs varies by program. The OCHIDS system, used by ODH and Medicaid-funded programs, defines a household as a single primary caregiver and a prenatal/target child. Other programs report data based on "adults served" and "children served" as opposed to "families or households served."
- **Inconsistent time periods for tracking data.** Data collected across home visiting programs is not tracked or reported using the same time periods. Programs report data by state fiscal year, calendar year, federal fiscal year and school year.

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[43] Health Resources and Services Administration. *Maternal, Infant and Early Childhood Home Visiting Program*. No date. Accessed May 12, 2020. https://mchb.hrsa.gov/sites/default/files/mchb/MaternalChildHealthInitiatives/HomeVisiting/FederalHomeVisitingProgramPerformanceIndicatorsandSystemsOutcomesSummary.pdf. Aligns with list of MIECHV performance measures provided by the Ohio Department of Health on May 18, 2020.

[44] Challenges identified by MCH/MIECHV Steering Committee members, key informant interviews, online survey respondents, Ohio Department of health staff and HPIO review of home visiting data provided for this Needs Assessment Update.

- **Lack of data from Ohio's Medicaid Managed Care and private health care insurance plans.** There is no public reporting of performance data for home visiting provided by health insurers in the state.
- **Double data entry across systems.** Home visiting providers may have to enter data into OCHIDS, in addition to other data systems, to comply with specific home visiting model requirements. In addition, providers affiliated with hospital systems may have "double" data entry due to Electronic Medical Record reporting requirements.
- **Barriers to accessing data.** Home visiting providers have expressed challenges in generating reports and pulling data out of OCHIDS to track their own capacity and performance.

Updates to OCHIDS

OCHIDS underwent updates based on the OCHIDS 3.0 IT project, which ran throughout 2019 and ended in February 2020. As part of this project, end users provided feedback on OCHIDS through a Lean Priority Survey conducted in June of 2019. The survey identified several OCHIDS programmatic areas requiring updates or enhancements (see Appendix H for a summary of survey results).

Updates made to OCHIDS during the 3.0 IT project included:

- Enhancements to increase reports available to monitor and track billing (e.g., new warrant report and billing potential and history report enhancements).
- Enhancements to capacity and caseload reports (e.g., addition of a capacity report and summary capacity report).
- New reports for Central Intake to track family exits and reasons for exit.
- Improved user functionality and navigation, including the ability to sort and filter on a variety of column headings across all OCHIDS reports.
- Enhanced tracking of referrals and referral outcomes, medical visits and insurance status.

The Innovate Ohio Platform (IOP) Health Data Portal website will be unveiled in the coming months. Four reports/dashboards for public viewing (provider list, home visits conducted, enrollment and system referrals received) are currently set for release through the IOP. Phase II of the IOP project is expected to deploy in late summer of 2020 and will include secure reports, making the line-level data home visiting providers entered into the OCHIDS data system available back to those providers. There are 28 OCHIDS reports being captured in Phase II that will provide data back to providers on many mission critical home visiting focus areas.

Part 4. Capacity for providing substance use disorder treatment and counseling services

This section summarizes key findings from the MIECHV substance use disorder treatment and capacity report (referred to as SUD report). The SUD report assesses the state's capacity for providing substance use disorder (SUD) counseling and treatment services to pregnant women and families with young children. The full report, in Appendix I, includes:

- Background and purpose.

- Scope of the challenge: Prevalence of SUD among pregnant women and families with young children.
- Current status of SUD treatment and wrap-around services for pregnant women and families with young children.
- Key informant interview findings.
- Discussion and conclusions.
- Next steps for a strategic approach.

Key findings

Given the significant challenge of addiction in Ohio, the state's capacity to provide effective SUD treatment and recovery services to pregnant women and families with young children is critical to the wellbeing of Ohio families. Going forward, Ohio can build upon the strengths described below to overcome gaps and barriers to SUD treatment services through stronger collaboration and coordination and more effective resource allocation.

Strengths

- **Policies designed to increase access.** Ohio has implemented several policies that are aimed at improving addiction treatment access for low-income pregnant women with SUD. For example, Medicaid eligibility levels are designed to increase access to care for pregnant women and the Ohio Department of Medicaid (ODM) continues to develop policies and programs to better serve this population. In addition, pregnant women are identified as a priority population for publicly-funded community behavioral health providers.
- **Programs for families.** The Ohio Attorney General's Office and the Ohio Department of Mental Health and Addiction Services (OMHAS) have led development of three major programs that serve the MIECHV population with SUD (START, MOMs Program and SAPT Women's Set-Aside), and these programs have reached hundreds of families.
- **Improvements in treatment capacity.** Some key informants perceived that there have been improvements in treatment capacity in recent years, particularly for access to medication-assisted treatment (MAT) and outpatient care.

Gaps and barriers

- **Not just opioids.** Marijuana, opioids, alcohol and tobacco use during pregnancy are all significant challenges. The prevalence of alcohol and tobacco use during pregnancy is higher in Ohio than in the U.S. overall. Marijuana has consistently been the most common substance used by Ohio women with SUD at the time of delivery, with use rising steadily from 2006 to 2018.
- **Troubling trends.** Ohio experienced a troubling upward trend in Neonatal Abstinence Syndrome (NAS) starting in 2006, with a peak in 2016 and slight decline in 2017 and 2018. This coincides with an upward trend of pregnant women with drug abuse or dependence diagnoses.
- **Child welfare.** Parental drug use is a major cause of children entering the child protection system. Over 38,000 cases were identified as having a concern with parental drug use by the Ohio Department of Job and Family Services in 2016.
- **Gaps in wrap-around services and recovery supports.**

    - Secondary data show that wrap-around services that are important to the MIECHV population—such as childcare provided during treatment—are relatively rare among Ohio addiction treatment providers, particularly in rural non-Appalachian and Appalachian counties.
    - In addition, there was widespread agreement among key informants that wrap-around services and recovery supports are not adequate to meet the current need of pregnant women and parents of young children.
    - Recovery housing was described as the most critical need, but childcare, transportation, education and employment are also described as significant unmet needs.
- **Limited program reach and reliance on federal grants.** While OhioSTART, the MOMs Program and SAPT Women's Set-Aside have reached hundreds of families, 53 counties do not have any of these programs. In addition, these programs rely primarily on federal grants and could be vulnerable to future funding cuts.
- **Gaps in treatment capacity.** Key informants cautioned that while Ohio has built treatment capacity in recent years (particularly for MAT), there are still many unmet needs. They noted that MAT is not effective for non-opioid SUD and that there is strong demand for residential treatment that cannot always be met in some communities.
- **Fragmented care.** Key informants noted that the complexity of the healthcare system makes it very difficult to navigate and that restrictions on data sharing limit the ability of different providers to coordinate care.
- **Lack of data.** Overall, state agencies in Ohio do not have timely, valid and reliable data on the capacity of the behavioral health system. It is therefore very difficult to determine what additional resources are needed, how those resources should be targeted and if recent efforts to improve capacity are working.
- **Lack of connections between SUD treatment providers and home visiting programs.** There does not appear to be strong collaboration between community SUD treatment providers and the Help Me Grow Home Visiting program. Key informants representing the SUD treatment and recovery perspective were not very familiar with home visiting, and there appear to be many opportunities for strengthened collaboration between OMHAS and the Ohio Department of Health (ODH) to drive improved coordination at the local level.

Opportunities for improvement and increased collaboration

- **Build data collection, data sharing and evaluation infrastructure.** Collect and analyze data on behavioral health treatment system capacity and effectiveness in a centralized way that supports future planning and evaluation and can be used to identify disparities and areas of unmet need.
- **Lead a comprehensive approach.** Ensure that Ohio's response to addiction is comprehensive and includes marijuana, alcohol and tobacco use during pregnancy, in addition to opioids and other illicit substances. Increase resources and develop a statewide strategy to address addiction-related harms during pregnancy, such as NAS and Fetal Alcohol Spectrum Disorder (FASD). Include multiple forms of treatment and recovery services, mother-baby dyad care and whole-family supports.

- **Extend the reach of existing programs.** Expand state-level programs that serve the MIECHV population with parental SUD (i.e., START, MOMs Program and SAPT Women's Set-Aside) so that at least one program is available in every Ohio county. Identify sustainable funding sources for these programs.
- **Expand wrap-around services.** Increase funding for and availability of wrap-around services for the MIECHV population, including:
    - Recovery housing.
    - Transportation to and childcare during addiction treatment.
    - Education and employment programs.
- **Strengthen partnerships with child welfare.** Develop stronger partnerships between addiction treatment providers and child protective services (CPS) and establish a statewide standard for the development of Plans of Safe Care for children born to women with SUD.
- **Strengthen partnerships with home visiting.** Increase collaboration between addiction treatment providers and home visiting programs, including greater use of data sharing agreements, improvements to the OCHIDS database and strategic partnerships among ODH and OMHAS.

Part 5. Coordination with Title V MCH Block Grant, Head Start and CAPTA needs assessments

The final requirement of the MIECHV Needs Assessment Update is to coordinate with and take into account requirements of federal needs assessments required under the Maternal and Child Health (MCH) Services Block Grant, Head Start Act and the Child Abuse Prevention and Treatment Act (CAPTA). Brief descriptions of each of these federal assessments and the administering entity in Ohio are provided below. This section also describes:

- Current agency coordination and collaboration.
- Qualitative and quantitative data collection.
- Recommendations for future coordination and collaboration.

Title V MCH Block Grant

The Ohio Department of Health (ODH) administers the MCH Block Grant and therefore, must conduct a comprehensive, statewide needs assessment every five years. ODH contracted with the Health Policy Institute of Ohio (HPIO) to conduct the population health status component of the five-year needs assessment due in 2020. HPIO was also commissioned by ODH to simultaneously conduct this MIECHV needs assessment, the 2019 State Health Assessment and develop the 2020-2022 State Health Improvement Plan. The intent of contracting with a single entity to complete each of these assessments and plans was to strengthen coordination and alignment.

CAPTA

The inventories required under CAPTA are completed by eight Regional Prevention Councils which receive funding from the Ohio Children's Trust Fund – Ohio's designated Community Based Child Abuse Prevention (CBCAP) lead. Funding is used to support programs and services to strengthen families and prevent child abuse and neglect. The required inventories are included in each region's prevention plan.

Head Start Act

Each Head Start grantee must conduct a community assessment at least once every five years and annually review and update the community assessment to reflect any significant changes or shifts in characteristics of the community.

Current agency coordination and collaboration

Coordination between the MIECHV and MCH needs assessment, the State Health Assessment (SHA) and the State Health Improvement Plan (SHIP)

To strengthen and streamline Ohio's population health assessment and planning efforts, ODH contracted with HPIO to simultaneously work on the MCH and MIECHV needs assessments and Ohio's 2019 SHA and 2020-2022 SHIP. This included convening a Steering Committee to provide input and guidance on MCH/MIECHV as well as the SHA and SHIP.

What are the SHA and SHIP?

SHA: The SHA is a document, updated every three years, that describes Ohio's health status and overall wellbeing, highlighting the state's many opportunities to improve health outcomes, reduce disparities and control healthcare spending. The 2019 SHA provides a comprehensive and actionable picture of health and wellbeing in Ohio. The 2019 SHA has two main components:

- Summary report prepared by HPIO, and
- Online, interactive data website prepared by ODH.

SHIP: The SHIP, also updated every three years, provides a roadmap to address the challenges highlighted in the SHA. The 2020-2022 SHIP includes a strategic menu of priorities, outcome objectives and evidence-based strategies to be implemented by state agencies, local health departments, hospitals and other community partners, including sectors beyond health.

The SHIP also identifies and sets targets for improving outcomes of "priority populations." Priority populations are communities identified as experiencing the worst outcomes compared to other Ohioans.

Both the SHA and SHIP are required for accreditation of ODH by the Public Health Accreditation Board.

Agency collaboration and joint stakeholder engagement

Representatives from Ohio's Head Start Collaboration Office and the Ohio Children's Trust Fund served on the MCH/MIECHV Steering Committee and provided input on the development of the MIECHV Needs Assessment Update. During the meetings, opportunities for ongoing state-level coordination with the Head Start Act and CAPTA were discussed. The final MIECHV Needs Assessment Update will be shared with members of the MCH/MIECHV Steering Committee and posted on ODH's website.

Quantitative and qualitative data collection

There were several ways in which data was collected and used for both the MCH and MIECHV needs assessments:

- Secondary (quantitative) data compiled and reviewed for the MCH needs assessment was useful for identifying the health challenges facing families most in need of home visiting.
- Five regional forums were held in Ohio to gather qualitative information from stakeholders related to strengths, challenges and equity issues surrounding Ohio women and children, as well as to identify the greatest needs of the five MCH population domains (maternal and women's health, perinatal and infant health, child health, children with special healthcare needs, adolescent and young adult health). An online survey was circulated to a larger group of stakeholders to gather additional input after the regional forums. Information gathered from the forums and survey, as well as secondary data analyzed for the MCH assessment, informed identification of the greatest challenges facing mothers, infants and young children in Ohio.
- Finally, key informant interviews conducted for the MIECHV Needs Assessment Update informed the MCH Block Grant needs assessment. For example, home visiting barriers and challenges discussed by key informants were useful in identifying opportunities for systems improvement in addressing the MCH population.

Information gathered provides additional insights related to community challenges that may be addressed through home visiting and can inform the implementation of evidence-based home visiting models in Ohio's at-risk communities.

Opportunities for future coordination and collaboration

- **Convene a single Steering Committee with multi-agency and multi-sectoral representation.** The MCH/MIECHV Steering Committee or a similar committee with multi-agency and sectoral representation could be retained and reconvened to inform and coordinate future federal needs assessments.
- **Collaborate on qualitative data collection.** There are various requirements in the MCH, MIECHV, CAPTA and Head Start needs assessments to gather input from community members, program participants, parents and other stakeholders. There is often considerable overlap in the populations served by these grant programs. For example, a family qualifying for MIECHV home visiting services is also likely to qualify for Head Start and programs funded through the MCH Block Grant. There are opportunities to collaborate effectively and efficiently on qualitative data collection, such as convening joint focus groups or co-developing surveys.
- **Improve strategic data sharing among state agencies.** There are overlapping data requirements for these assessments. Sharing data is important to avoid duplication of efforts and ensure that Ohioans most at risk for poor outcomes are being served. There is likely considerable overlap in populations served by these grants. Consequently, data collected for one needs assessment could strengthen and inform other needs assessments. For example, data collected for Head Start assessments can inform development of MCH programs and home visiting readiness.
- **Develop a cross-agency data warehouse**. The MCH/MIECHV Steering Committee recommended that Ohio develop a single data warehouse that houses cross-

agency data, including data required for all of the needs assessments. Improving platforms for compiling and analyzing data from various state agencies, such as the Ohio Data Analytic project, is a priority of Ohio's current Governor, Mike DeWine, as well as for previous administrations, and this work is ongoing.

Part 6. Key findings

Ohio decisionmakers and other home visiting partners should consider the following key findings in efforts to serve more families in need of home visiting and strengthen Ohio's current home visiting system.

Key finding #1. Home visiting need is concentrated in 27 Ohio counties. Statewide, 84,035 families were estimated to be in need of home visiting services based on CY 2017 data from the Health Resources and Services Administration. Of families in need of home visiting services, 63.2% (53,059 families) were from 27 Ohio counties identified as "at-risk communities" based on socioeconomic status, adverse perinatal outcomes, substance use disorder, crime and child maltreatment data.

Eight of these at-risk counties did not receive MIECHV funding in FFY 2019: Athens, Butler, Guernsey, Highland, Jackson, Lawrence, Morgan and Muskingum.

Key finding #2. Home visiting data collection, resource allocation and strategy implementation can be strengthened to eliminate disparities and advance equity. Within Ohio's 27 at-risk counties, large disparities exist across many of the measures, such as poverty and preterm birth, that are predictive of home visiting need. Early childhood home visiting strategies can be most successful in reducing disparities and advancing equity if:

- Comprehensive and complete demographic data and information from home visiting enrollees is collected and reported to identify disparities and measure the outcomes of home visiting interventions specific to at-risk families.
- Resources are allocated and strategies are targeted, tailored and culturally adapted to meet the needs of at-risk counties and other at-risk populations, such as communities of color and families with low educational attainment.
- State and local partners actively surface and directly address racism and discrimination that may be present in the home visiting system and partner systems (i.e., child welfare, behavioral health, early intervention, etc.).

Key finding #3. There are different types of home visiting models operating in Ohio with varying reach. There are six home visiting models operating in Ohio identified as "evidence-based" by the U.S. Department of Health and Human Services (HHS) Home Visiting Evidence of Effectiveness (HomVEE) review. Of these, Healthy Families America (HFA) served the largest number of families in 2019 (7,544), followed by Early Head Start (EHS) Home-Based option (4,126), Nurse Family Partnership (NFP) (1,518), Parents as Teachers (PAT) (826), Home Instruction for Parents of Preschool Youngsters (HIPPY) (111) and SafeCare Augmented (90).

There are other non-HomVEE-designated programs operating in Ohio that provide home visiting services and related supports to many families. There may be overlap in

families served through these programs and those served through HomVEE-designated models. Programs include Moms and Babies First, Certified Pathways Community HUBs, SPARK, Healthy Start and home visiting services provided through private health insurers and Medicaid managed care organizations.

Key finding #4. Ohio still has a large unmet need for home visiting. Of the 84,035 families estimated to need home visiting services in Ohio, 14,215 households were served through one of Ohio's evidence-based HomVEE-designated models in 2019. This represents only 16.9% of the total estimated number of Ohio families in need of home visiting services.

Of those served through a HomVEE model, 8,776 were from one of Ohio's 27 at-risk communities. This indicates that only 16.5% of the estimated number of families in need of home visiting services in at-risk communities (53,059 families) were served in 2019. Factors limiting the extent to which Ohio home visiting programs meet the estimated need for home visiting services include, but are not limited to, home visiting program eligibility requirements, funding limitations and provider capacity.

Key finding #5. Ohio Department of Health Help Me Grow Home Visiting (ODH HMGHV) HomVEE programs serves the largest number of Ohioans. Of the 14,215 households served through one of Ohio's evidence-based HomVEE models in 2019, 61.6% (8,755 households) were served through an ODH HMGHV HomVEE program, 6.3% (897 households) were served through an Ohio Department of Medicaid-funded program, and the remaining 32.1% (4,563 households) were served through other HomVEE programs operating across the state.

Other HomVEE programs include EHS Home-Based Option, SafeCare Augmented, HIPPY, Piqua PAT, My Baby & Me HFA and HFA and PAT programs funded by the Ohio Children's Trust Fund.

Key finding #6. Home visiting providers in Ohio face challenges with family engagement, funding, eligibility restrictions, staffing, community resources and coordination. Top challenges identified by home visiting providers through an online survey and key informant interviews include issues with the initial engagement and retention of families in home visiting services, inadequate funding and home visiting model eligibility restrictions. Providers also expressed concerns with staff hiring and retention due to low compensation, candidates lacking the required experience or degrees and high stress/burnout among staff.

Home visiting providers also identified community resources with notable gaps in the availability of services for families in need. The top-five areas with gaps in services included childcare, housing assistance, diaper banks and both parental and pediatric mental health treatment, services and supports.

About a quarter of home visiting providers surveyed indicated that home visiting programs in their county made or shared referrals and/or provided transition support to one another or that there was strong collaboration/coordination in their county. In

contrast, several providers noted a lack of collaboration and competitiveness among home visiting providers in their county.

Key finding #7. Ohio has a unique opportunity to build on current support for home visiting to strengthen the system's capacity, quality and reach. Ohio's Executive and Legislative branches of government have provided strong policy and fiscal support for home visiting services. Ohio can build on this support by making state-level improvements in the administration and coordination of the home visiting system by:

- Promoting a unified approach to home visiting that includes common home visiting definitions and goals among home visiting programs and their partners.
- Developing a comprehensive referral system to increase referrals to home visiting from child protective services, the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), Medicaid, the Department of Developmental Disabilities and other entities.
- Increasing funding for and implementing changes to reimbursement models to support home visiting.
- Increasing the frequency of state-level meetings and improving communication across state and local level agencies to strengthen partnerships and identify coordinated approaches to address gaps in home visiting services.
- Building on ODH's Ohio Comprehensive Home Visiting Integrated Data System to create a centralized and standardized data system that all home visiting programs report to for data tracking and sharing. This includes tracking performance/outcome measures and disaggregated data to support quality improvement initiatives, eliminating disparities and advancing equity.
- Increasing collaboration and coordination between MIECHV and other federal needs assessments by convening a shared Steering Committee with multi-agency and multi-sectoral representation, collaborating on qualitative data collection and analysis and improving cross-agency data sharing.

Part 7. Appendices

- Appendix A: MIECHV Needs Assessment Data Summary Excel files
    - Appendix A.1: Separate Excel file - Needs Assessment Data Summary_OHIO
    - Appendix A.2: Separate Excel file - Supplemental Data_OHIO
- Appendix B: Ohio counties identified as "at-risk" by domain
- Appendix C: Ohio county types and Ohio Department of Health home visiting regions
- Appendix D: Additional information on qualitative data sources
- Appendix E: Assessment of home visiting capacity in Ohio - Additional information
    - Additional information on individuals and families receiving home visiting services through ODH-administered programs
    - Percent of need met through ODH-administered Help Me Grow Home Visiting HomVEE programs, by county
    - Percent of need met through all HomVEE-designated evidence-based home visiting programs, by county
    - Percent of need met through HomVEE-designated evidence-based home visiting programs, by ODH home visiting region
    - Home visiting programs operating in at-risk communities
- Appendix F: Ohio Home Visiting Provider Capacity and Readiness Assessment Online Survey
- Appendix G: Supplemental information on home visiting capacity and quality
- Appendix H: Supplemental information on state-level initiatives
- Appendix I: Assessment of Ohio's capacity to provide substance use disorder treatment and counseling services

Appendix A: MIECHV Needs Assessment Data Summary Excel Files

See excel appendices

Appendix B: Ohio counties identified as "at-risk" by domain

Socioeconomic status

Sixteen of Ohio's 88 counties are identified as at-risk in the socioeconomic status domain (see figure B.1). Many of the counties identified as at-risk are Appalachian counties in the south and southeast portions of the state, along with a cluster of counties in the northeast.

Figure B.1. **Ohio counties at-risk: Socioeconomic status domain, CY 2017**

Note: Counties with outcomes that are at least one standard deviation worse than the mean for all Ohio counties for at least 50% of indicators in a domain are considered at-risk for that domain.
Source: HPIO analysis of data provided by the Health Resources and Services Administration

Adverse perinatal outcomes

Eighteen Ohio counties are identified as at-risk in the adverse perinatal outcomes domain (see figure B.2). Seven of the counties identified accounted for more than half of all infant deaths in the state in 2017. These counties are Cuyahoga, Franklin, Hamilton, Lucas, Mahoning, Montgomery and Summit.[45]

Substance use disorder

The substance use disorder domain includes the highest number of at-risk counties, with 26 of Ohio's 88 counties identified as at-risk (see figure B.3). Indicators of alcohol, marijuana, illicit drug use and non-medically indicated pain reliever use were examined as part of this domain. Counties identified as at-risk are primarily within the southern and Appalachian regions of the state, many of which were especially hard hit by the opioid epidemic.

Notably, 21 of the 26 counties identified as at-risk in the substance use disorder domain were also identified as at-risk in at least one other domain.

Figure B.2. **Ohio counties at-risk: Adverse perinatal outcomes domain, CY 2017**

Note: Counties with outcomes that are at least one standard deviation worse than the mean for all Ohio counties for at least 50% of indicators in a domain are considered at-risk for that domain.
Source: HPIO analysis of data provided by the Health Resources and Services Administration

Figure B.3. **Ohio counties at-risk: Substance use disorder domain, CY 2017**

Note: Counties with outcomes that are at least one standard deviation worse than the mean for all Ohio counties for at least 50% of indicators in a domain are considered at-risk for that domain. This map was developed using additional substance use disorder metrics. Data for the additional substance use disorder metrics is more recent (pooled years 2014-2016) than data provided in the draft Supplemental Information Request (SIR) (pooled year 2012-2014).
Source: HPIO analysis of data provided by the Health Resources and Services Administration

[45] *2017 Ohio Infant Mortality Report: General findings.* Ohio Department of Health, July 2019. https://odh.ohio.gov/wps/portal/gov/odh/know-our-programs/infant-and-fetal-mortality/reports/2017-ohio-infant-mortality-report-final

Crime

Twenty-one Ohio counties are identified as at-risk in the crime domain (see figure B.4). Unlike many of the other domains, a geographic pattern is less apparent in this domain. The seven most populated counties in Ohio (Franklin, Cuyahoga, Hamilton, Summit, Montgomery, Lucas and Butler) are at-risk, along with a handful of other counties, many of which are in the western half of the state.

Child maltreatment

Twelve Ohio counties are identified as at-risk for child maltreatment, a smaller number of counties than in any of the other domains (see figure B.5).

Figure B.4. **Ohio counties at-risk: Crime domain, CY 2017**

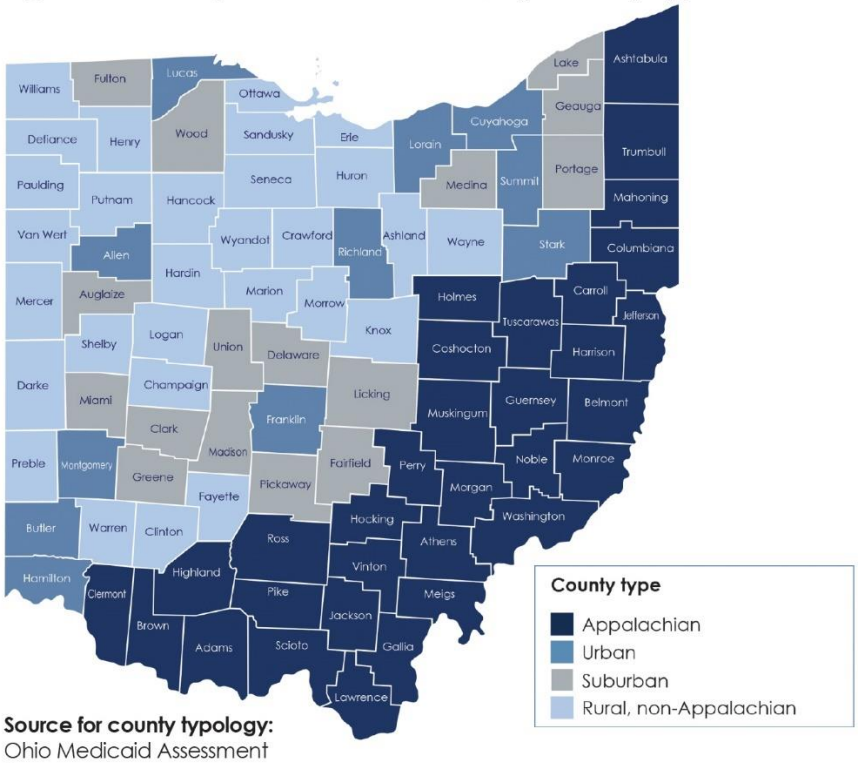
Note: Counties with outcomes that are at least one standard deviation worse than the mean for all Ohio counties for at least 50% of indicators in a domain are considered at-risk for that domain.
Source: HPIO analysis of data provided by the Health Resources and Services Administration

Figure B.5. **Ohio counties at-risk: Child maltreatment domain, CY 2017**

Note: Counties with outcomes that are at least one standard deviation worse than the mean for all Ohio counties for at least 50% of indicators in a domain are considered at-risk for that domain.
Source: HPIO analysis of data provided by the Health Resources and Services Administration

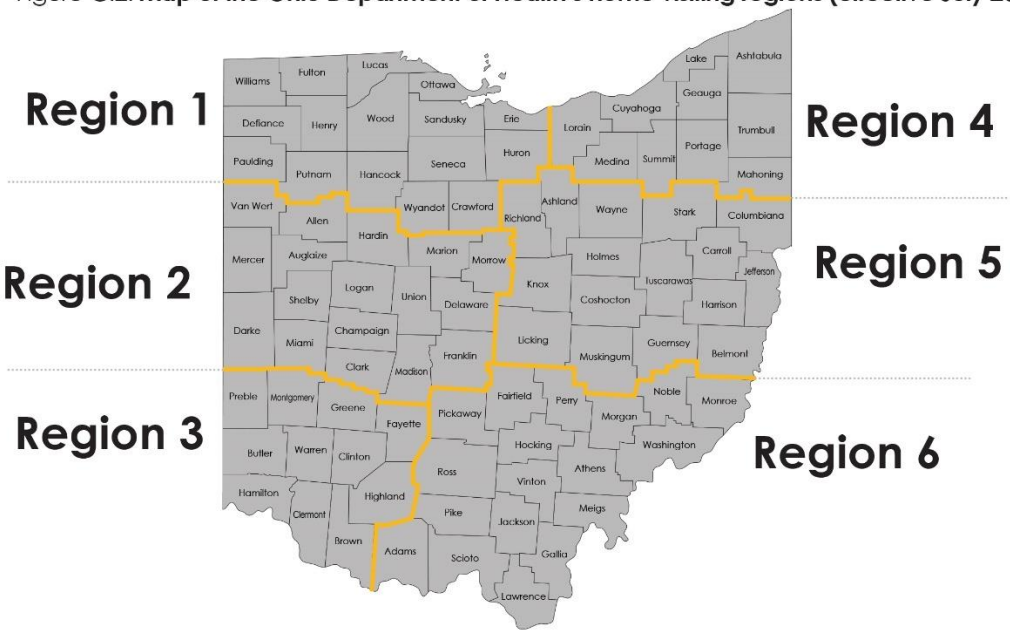
Appendix C: Ohio county types and Ohio Department of Health (ODH) home visiting regions

Figure C.1. **Map of Ohio counties, by county type**



Source for county typology:
Ohio Medicaid Assessment Survey

Figure C.2. **Map of the Ohio Department of Health's home visiting regions (effective July 2020)**



Source: Ohio Department of Health

Appendix D. Additional information on qualitative data sources

Key informant interviews

Of the 15 organizations interviewed, 13 were home visiting providers or funders/payers of home visiting services, representing a variety of models and programs; five were state agencies or commissions; one was a health insurance company/Medicaid managed care plan and one was a statewide advocacy organization. Some key informants were in more than one of these categories.

Home visiting providers interviewed represented all geographic regions of the state and included both large urban and small rural programs.

All three of the Ohio Department of Health (ODH) Help Me Grow (HMG) HomVEE home visiting models (Nurse-Family Partnership, Healthy Families America and Parents as Teachers) were represented in provider interviews, as well as organizations that provide services or funding for other home visiting models and programs, including the Pathways Community HUBs, Early Head Start, SPARK, Moms and Babies First and Early Intervention services.

Examples of topics on which interviewees provided feedback include:

- **Barriers and challenges** faced by home visiting providers at the local level.
- **Opportunities for improvement in state-level coordination and administration** of home visiting.
- **Community readiness** related to staffing/workforce capacity and community resources.

Ohio Home Visiting Provider Capacity and Readiness Assessment Online Survey and Forums

The Ohio Home Visiting Provider Capacity and Readiness Assessment Online Survey consisted of 23 questions (combination of multiple choice and open-ended questions). A total of 99 responses from 95 home visiting providers were submitted; four organizations submitted more than one survey response.

There was representation from across the state, with 81 of Ohio's counties represented by at least one survey respondent. Survey representation across the county types and ODH home visiting regions are shown in figures D.1 and D.2.

Figure D.1. **Online survey respondents, by county type**

County type	Number of respondents representing at least one county of this type
Appalachian	27
Urban	44
Suburban	20
Rural, non-Appalachian	28

Note: One provider may serve multiple county types

Figure D.2. **Online survey respondents, by ODH home visiting region**

ODH Home visiting region	Number of respondents representing at least one county in this region
Region 1	15
Region 2	27
Region 3	17
Region 4	19
Region 5	19
Region 6	14

Figure D.3 shows representation across home visiting models and programs.

Figure D.3. **Home visiting models and programs represented in online survey responses**

Home visiting model or program	Number of respondents
Healthy Families America*	51
Early Head Start – home-based option*	21
Parents as Teachers*	16
Nurse-Family Partnership*	7
SafeCare Augmented*	2
HIPPY*	1
SPARK	10
Pathways Community HUB	7
Moms and Babies First	5
Healthy Start	3

*Indicates an evidence-based home visiting model based on the Department of Health and Human Services (HHS) Home Visiting Evidence of Effectiveness (HomVEE) list
Note: Some respondents operate multiple home visiting models or programs

There were 20 survey respondents that represented more than one home visiting model or program. Therefore, their responses were applied to multiple models.

A total of 73 attendees participated in an interactive forum (webinar) to review the results of the online survey and provide additional feedback on April 22, 2020. There were 54 attendees who participated in the webinar on April 23, 2020.

Maternal and Child Health (MCH)/Maternal, Infant and Early Childhood Home Visiting (MIECHV) Steering Committee

The Steering Committee was composed of 31 child health and home visiting experts representing 27 organizations from around the state, including representatives from the following state agencies, commissions and advisory groups:

- Ohio Department of Health.
- Ohio Department of Medicaid.
- Ohio Department of Developmental Disabilities.
- Ohio Department of Mental Health and Addiction Services.
- Ohio Department of Education.
- Ohio Department of Job and Family Services.

- Ohio Commission on Minority Health.
- Ohio Children's Trust Fund.
- Governor's Office of Children's Initiatives.
- Office of Children Services Transformation.
- Ohio Family 2 Family.

This Steering Committee met five times (virtually and in-person) between January 31, 2019 and May 6, 2020. Information about the Steering Committee meetings is available on HPIO's website. Steering committee member names and organizations are listed below.

Figure D.4. **MCH/MIECHV Steering Committee members as of May 6, 2020**

Dr. Mary	**Applegate**	Ohio Department of Medicaid
Anita	**Armstrong**	Ohio Department of Education, Head Start Collaboration Office
Tara	**Britton**	The Center for Community Solutions
Erika	**Clark Jones**	Formerly with City of Columbus, CelebrateOne
LeeAnne	**Cornyn**	Office of the Governor
Nathan	**DeDino**	Ohio Department of Developmental Disabilities
Jody	**Demo-Hodgins**	National Alliance on Mental Illness of Ohio (NAMI Ohio)
Julie	**DiRossi-King**	Ohio Association of Community Health Centers
Dr. Michelle	**Dritz**	Cornerstone Pediatrics and the Ohio Chapter of the American Academy of Pediatrics
Tonya	**Fulwider**	Mental Health America of Franklin County
Dr. Pat	**Gabbe**	Ohio State University College of Medicine and Nationwide Children's Hospital
Fawn	**Gadel**	Public Children Services Association of Ohio
Shannon	**Jones**	Groundwork Ohio
Sarah	**Kincaid**	Ohio Children's Hospital Association
Nick	**Lashutka**	Ohio Children's Hospital Association
Briana	**Lusheck**	Office of the Governor
Ilka	**Riddle**	University of Cincinnati and Cincinnati Children's Hospital
Ann	**Robinson**	The Ohio State University
Donna	**Schwarber**	Butler County Educational Service Center
Stephanie	**Siddens**	Ohio Department of Education
Reina	**Sims**	Ohio Commission on Minority Health
Molly	**Stone**	Ohio Department of Mental Health and Addiction Services
Cherrelle	**Turner**	Office of Children Services Transformation & The Governor's Office of Children's Initiatives
Dr. Judy	**Van Ginkel**	Every Child Succeeds
Josue	**Vicente**	Ohio Hispanic Coalition
Mary	**Wachtel**	Public Children Services Association of Ohio
Angela	**Weaver**	Ohio Association of Health Plans
Melissa	**Wervey Arnold**	Ohio Chapter of the American Academy of Pediatrics
Lindsay	**Williams**	Ohio Children's Trust Fund
Lynanne	**Wolf**	Groundwork Ohio
Ashlee	**Young**	Formerly with Strive Partnership

Ohio Department of Health (ODH) Bureau of Maternal, Child and Family Health staff

HPIO gathered input from ODH staff at multiple points during the process of creating this report including:

- **June 13, 2019 ODH staff meeting**: HPIO presented preliminary data from the MIECHV key informant interviews and substance use disorder (SUD) findings and gathered feedback on the most notable findings and other issues to be explored.
- **June 14, 2019 ODH home visiting staff meeting**: HPIO and ODH staff discussed home visiting data availability and limitations.

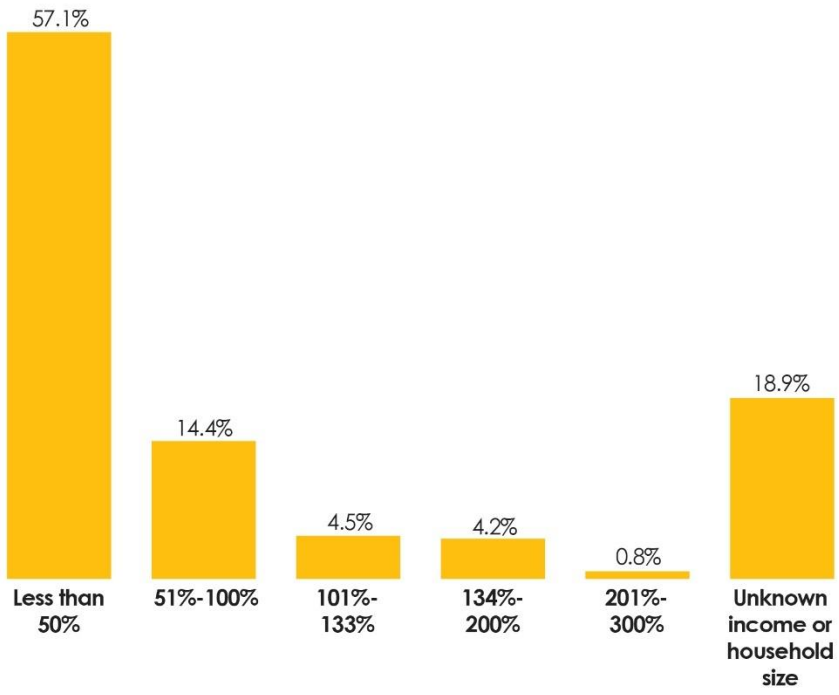
Appendix E: Assessment of home visiting capacity in Ohio - Additional information

Additional information on individuals and families receiving home visiting services through ODH-administered programs

Income

Figure E.1 shows the incomes of enrollees. A total of 71.5% had incomes at or below the federal poverty level (FPL).

Figure E.1. **Pregnant women and primary caregivers enrolled in ODH HMGHV HomVEE programs in FFY 2019, by income** (N=8,755)



Note: Includes HomVEE programs funded through HMGHV state funding and MIECHV federal funding
Source: Ohio Department of Health

Non-English speakers

Only 6.9% of ODH HomVEE home visiting participants in FFY 2019 were non-English speakers. The two counties with the highest percentages of non-English speaking enrollees were Hamilton and Franklin, which contain two of Ohio's largest cities (Cincinnati and Columbus respectively).

Average age

The average maternal age at enrollment in HMGHV HomVEE programs was 25.5 years, and 26.9 years for MIECHV-funded programs. A total of 59.3% of HomVEE program enrollees were first-time caregivers, compared to only 34.8% of Moms and Babies First program enrollees.

Percent of need met through ODH-administered Help Me Grow Home Visiting (HMGHV) HomVEE programs, by county

Figure E.2. **Percent of need met through ODH-administered HMGHV HomVEE programs in FFY 2019, by county** (At-risk communities are highlighted in green)

County	Total served through an ODH HomVEE programs	HRSA-provided estimated number of families in need of home visiting services	Percent of those in need served through an ODH HMGHV HomVEE program
Adams	41	225	18.22%
Allen	83	1,095	7.58%
Ashland	18	393	4.58%
Ashtabula	179	1,745	10.26%
Athens	58	343	16.91%
Auglaize	22	246	8.94%
Belmont	36	251	14.34%
Brown	31	299	10.37%
Butler	170	1,043	16.30%
Carroll	23	220	10.45%
Champaign	1	136	0.74%
Clark	279	1,445	19.31%
Clermont	51	1,423	3.58%
Clinton	54	338	15.98%
Columbiana	109	462	23.59%
Coshocton	48	154	31.17%
Crawford	133	451	29.49%
Cuyahoga	742	11,725	6.33%
Darke	45	108	41.67%
Defiance	28	252	11.11%
Delaware	6	479	1.25%
Erie	58	546	10.62%
Fairfield	41	1,080	3.80%
Fayette	130	374	34.76%
Franklin	545	10,271	5.31%
Fulton	29	157	18.47%
Gallia	38	156	24.36%
Geauga	4	416	0.96%
Greene	44	555	7.93%
Guernsey	25	164	15.24%
Hamilton	1,263	6,168	20.48%
Hancock	80	291	27.49%
Hardin	13	111	11.71%
Harrison	66	30	220.00%

Henry	42	182	23.08%
Highland	44	347	12.68%
Hocking	43	288	14.93%
Holmes	22	184	11.96%
Huron	62	427	14.52%
Jackson	49	331	14.80%
Jefferson	164	244	67.21%
Knox	23	691	3.33%
Lake	32	836	3.83%
Lawrence	0	587	0.00%
Licking	43	290	14.83%
Logan	0	159	0.00%
Lorain	202	2,562	7.88%
Lucas	439	2,645	16.60%
Madison	32	128	25.00%
Mahoning	373	2,708	13.77%
Marion	113	739	15.29%
Medina	25	615	4.07%
Meigs	26	120	21.67%
Mercer	25	219	11.42%
Miami	39	509	7.66%
Monroe	7	107	6.54%
Montgomery	530	4,917	10.78%
Morgan	12	111	10.81%
Morrow	25	399	6.27%
Muskingum	58	778	7.46%
Noble	25	108	23.15%
Ottawa	9	113	7.96%
Paulding	29	124	23.39%
Perry	47	324	14.51%
Pickaway	13	170	7.65%
Pike	95	286	33.22%
Portage	37	1,465	2.53%
Preble	1	86	1.16%
Putnam	67	131	51.15%
Richland	67	879	7.62%
Ross	68	1,005	6.77%
Sandusky	34	430	7.91%
Scioto	69	736	9.38%
Seneca	5	593	0.84%
Shelby	32	102	31.37%
Stark	227	3,827	5.93%
Summit	230	4,454	5.16%
Trumbull	185	1,869	9.90%
Tuscarawas	70	178	39.33%

Union	6	164	3.66%
Van Wert	14	152	9.21%
Vinton	90	132	68.18%
Warren	28	614	4.56%
Washington	53	456	11.62%
Wayne	69	461	14.97%
Williams	20	244	8.20%
Wood	25	420	5.95%
Wyandot	40	237	16.88%
County data missing	177		
Ohio Total	**8,755**	**84,035**	**10.42%**

Note: At-risk communities are highlighted in green
Sources: Numbers served provided by the Ohio Department of Health. Estimated need provided by the Health Resources and Services Administration based on analysis of data from the U.S. Census Bureau, American Community Survey.

Percent of need met through all HomVEE-designated evidence-based home visiting programs, by county

Figure E.3. **Percent of need met through HomVEE-designated evidence-based home visiting programs, by county (data years vary)**

County	Total served through HomVEE programs	HRSA-provided estimated number of families in need of home visiting services	Percent of those in need served through a HomVEE model
Adams	41	225	18.22%
Allen	180	1,095	16.44%
Ashland	18	393	4.58%
Ashtabula	249	1,745	14.27%
Athens	145	343	42.27%
Auglaize	53	246	21.54%
Belmont	36	251	14.34%
Brown	202	299	67.56%
Butler	346	1,043	33.17%
Carroll	23	220	10.45%
Champaign	33	136	24.26%
Clark	348	1,445	24.08%
Clermont	283	1,423	19.89%
Clinton	54	338	15.98%
Columbiana	110	462	23.81%
Coshocton	72	154	46.75%
Crawford	133	451	29.49%
Cuyahoga	1,317	11,725	11.23%
Darke	65	108	60.19%

Defiance	39	252	15.48%
Delaware	6	479	1.25%
Erie	58	546	10.62%
Fairfield	239	1,080	22.13%
Fayette	205	374	54.81%
Franklin	740	10,271	7.20%
Fulton	29	157	18.47%
Gallia	38	156	24.36%
Geauga	4	416	0.96%
Greene	75	555	13.51%
Guernsey	154	164	93.90%
Hamilton	1,746	6,168	28.31%
Hancock	80	291	27.49%
Hardin	13	111	11.71%
Harrison	66	30	220.00%
Henry	42	182	23.08%
Highland	108	347	31.12%
Hocking	97	288	33.68%
Holmes	22	184	11.96%
Huron	62	427	14.52%
Jackson	49	331	14.80%
Jefferson	164	244	67.21%
Knox	66	691	9.55%
Lake	141	836	16.87%
Lawrence	117	587	19.93%
Licking	139	290	47.93%
Logan	27	159	16.98%
Lorain	218	2,562	8.51%
Lucas	495	2,645	18.71%
Madison	70	128	54.69%
Mahoning	508	2,708	18.76%
Marion	113	739	15.29%
Medina	146	615	23.74%
Meigs	26	120	21.67%
Mercer	25	219	11.42%
Miami	158	509	31.04%
Monroe	51	107	47.66%
Montgomery	1,026	4,917	20.87%
Morgan	30	111	27.03%
Morrow	25	399	6.27%
Muskingum	70	778	9.00%
Noble	62	108	57.41%
Ottawa	33	113	29.20%

Paulding	29	124	23.39%
Perry	111	324	34.26%
Pickaway	146	170	85.88%
Pike	147	286	51.40%
Portage	163	1,465	11.13%
Preble	17	86	19.77%
Putnam	67	131	51.15%
Richland	95	879	10.81%
Ross	68	1,005	6.77%
Sandusky	78	430	18.14%
Scioto	175	736	23.78%
Seneca	33	593	5.56%
Shelby	57	102	55.88%
Stark	257	3,827	6.72%
Summit	422	4,454	9.47%
Trumbull	190	1,869	10.17%
Tuscarawas	70	178	39.33%
Union	6	164	3.66%
Van Wert	34	152	22.37%
Vinton	90	132	68.18%
Warren	67	614	10.91%
Washington	85	456	18.64%
Wayne	208	461	45.12%
Williams	31	244	12.70%
Wood	35	420	8.33%
Wyandot	40	237	16.88%
County data missing	204	N/A	N/A
Ohio Total	**14,215**	**84,035**	**16.92%**

Note: At-risk communities are highlighted in green
Sources: Estimate of families in need of home visiting services derived from 2017 American Community Survey data provided by the Health Resources Services Administration; Number of families served data is from the Ohio Department of Health (FFY 2019), Ohio Children's Trust Fund (SFY 2019), Ohio Head Start Collaboration Office (FFY 2019), YWCA of Greater Cincinnati (FFY 2019), the Children's Home of Cincinnati (July 2018-June 2019), Columbus Public Health (FFY 2019) and Piqua Parents as Teachers (FFY 2019).

Percent of need met through HomVEE-designated evidence-based home visiting programs, by Ohio Department of Health (ODH) home visiting region

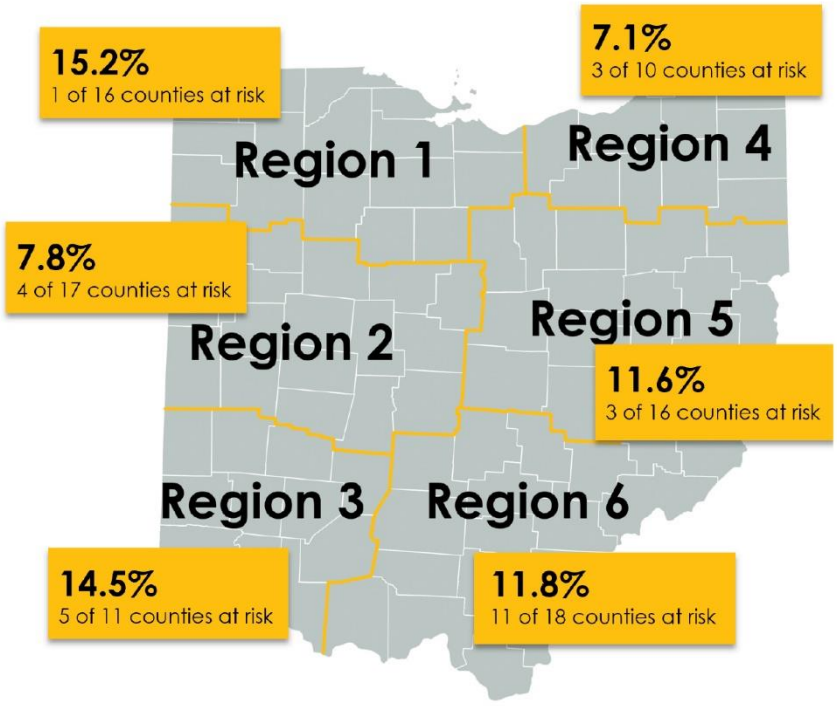
Beginning in July of 2020, ODH will administer its Help Me Grow Home Visiting (HMGHV) programs using six home visiting regions. A more detailed map of regions including county names is in Appendix C.2.

Figure E.4 shows the percent of need met for ODH's six home visiting regions through ODH-administered HomVEE programs only. The northeastern corner of the state had the

lowest (7.1%), and the northwestern corner had the highest percent of need met (15.2%) in FFY 2019.

Figure E.5 shows the percent of need met through all HomVEE programs for the six home visiting regions. Again, Region 4 (northeast) had the lowest percent of estimated need met through all HomVEE programs at 11.8%; however, Region 6 had the highest, at 26.2%. The percent of need met in Region 6 more than doubled, from 11.8% to 26.2%, from the analysis which only included the ODH-administered HomVEE models. This is largely due to Early Head Start.

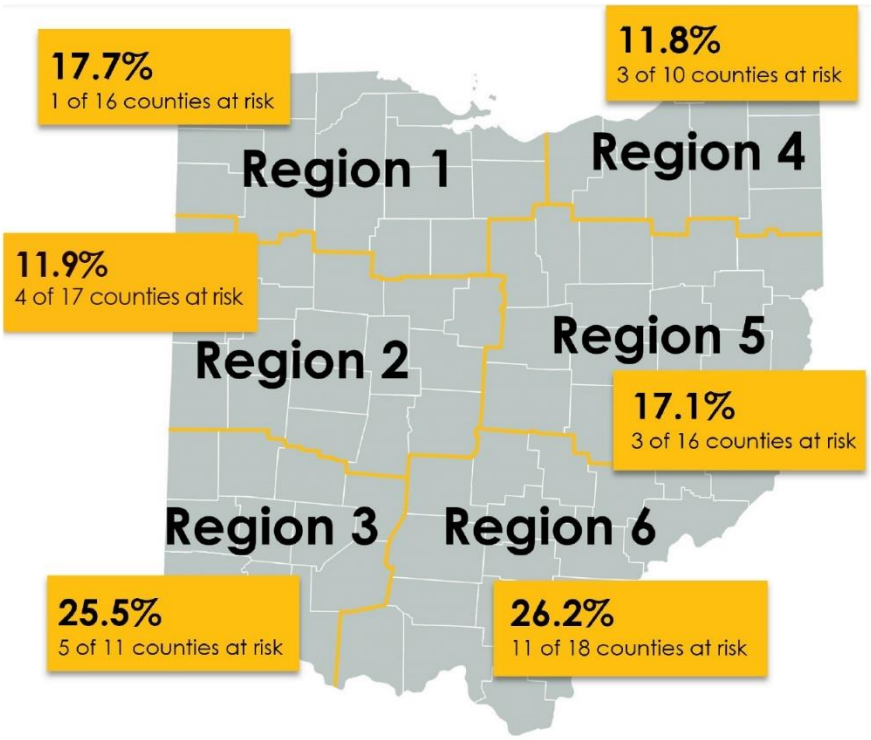
Figure E.4 **Estimated percentage of need met through ODH HMGHV HomVEE programs, by ODH home visiting region, FFY 2019**



Source: Estimate of families in need of home visiting services derived from 2017 American Community Survey data provided by the Health Resources Services Administration; Number of families served data is from the Ohio Department of Health and includes families served through HMG Home Visiting, including MIECHV-funded programs (HFA, NFP and PAT) for FFY 2019

Conversely, the percent of need met in Region 1 increased only slightly from 15.2% in the analysis of only ODH-administered HomVEE programs to 17.7% when all HomVEE programs were included (a 7% increase). Only 184 additional households throughout the region were served through a non-ODH administered HomVEE program (1,100 to 1,284).

Figure E.5. **Estimated percentage of need met through any HomVEE model, by ODH home visiting region, 2019**



Source: Survey data provided by the Health resources Services Administration; Number of families served data is from the Ohio Department of Health (FFY 2019), Ohio Children's Trust Fund (SFY 2019), Ohio Head Start Collaboration Office (FFY 2019), YWCA of Greater Cincinnati (FFY 2019), the Children's Home of Cincinnati (July 2018-June 2019), Columbus Public Health (FFY 2019) and Piqua Parents as Teachers (FFY 2019).

The two regions with the highest percent of need met through all HomVEE programs, Regions 3 and 6 in southern Ohio, had the highest proportions of at-risk counties. In Region 3, 5 of the 11 counties (45%) are at-risk. In Region 6, 11 of the 18 counties (61%) are at-risk counties.

Home visiting programs operating in at-risk communities

Figure E.6 lists Ohio's at-risk communities and the types of home visiting models and programs operating in each. Hamilton and Cuyahoga have the most different types of home visiting models/programs operating in their counties, with eight in each. Summit and Franklin Counties each had seven programs. At-risk communities with only one type of home visiting program operating in their county were: Adams, Gallia, Jackson, Marion, Meigs, Ross and Vinton.

Figure E.6. **Scan of home visiting program/model types operating in at-risk communities in Ohio, data years vary**

	HomVEE-designated evidence-based model						Non-HomVEE designated models			
At-risk community	**HFA*** (FFY 2019)	**NFP*** (FFY 2019)	**PAT*** (FFY 2019)	**Early Head Start (Home-based)*** (FFY 2019)	**SafeCare Augmented*** (FFY 2019)	**HIPPY*** (July 2018-June 2019)	**Moms & Babies First** (FFY 2019)	**Pathways Community HUB** (FFY or CY 2019)	**SPARK** (2019 & 2020 cohorts)	**Healthy Start awardee site** (FFY or CY 2019)
Adams**	X									
Allen**	X			X			X			
Athens	X			X						
Butler	X	X		X			X	X	X	
Clark**	X			X			X		X	
Coshocton**	X			X				X		
Cuyahoga**	X	X	X	X			X	X	X	X
Fayette**	X			X						
Franklin**	X	X		X			X	X	X	X
Gallia**	X									
Guernsey	X			X				X		
Hamilton**	X			X	X	X	X	X	X	X
Highland	X			X						
Jackson	X									
Lawrence				X						
Lucas**	X		X	X			X	X		X
Mahoning**	X	X		X				X	X	
Marion**	X									
Meigs**	X									
Montgomery**	X	X		X			X	X		X
Morgan			X	X						
Muskingum	X			X				X		
Pike**	X			X						
Ross**	X									
Scioto**	X			X						
Summit**	X	X	X	X			X	X	X	
Vinton**	X									

**Counties received MIECHV funding in CY 2019

Note: Home visiting financed by private health insurance companies and Medicaid managed care organizations are not included

Source: Program information is displayed based on data and information collected from multiple sources reflecting different time periods. The time period of the source is indicated in the header under each program. Sources are included in the Methods, data sources and stakeholder engagement section of this report

Appendix F: Ohio Home Visiting Provider Capacity and Readiness Assessment Online Survey

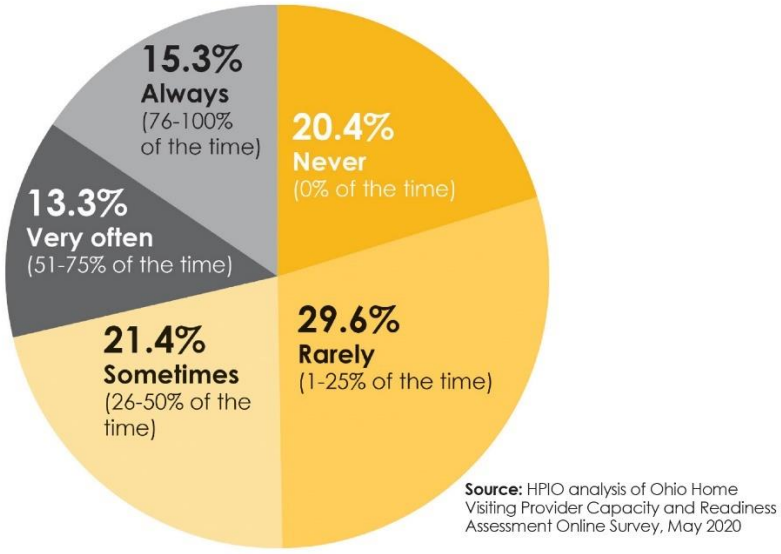
See Appendix F PDF

Appendix G: Supplemental information on home visiting capacity and quality

Home visiting provider waitlists

Online survey respondents were asked how often their home visiting program(s) had a waitlist. Responses are displayed in figure G.1.

Figure G.1. **"How often do you have waitlists for your home visiting program(s)?"** (N=98)



Source: HPIO analysis of Ohio Home Visiting Provider Capacity and Readiness Assessment Online Survey, May 2020

Waitlist information for ODH-administered and ODM-funded home visiting programs

From Aug. 2019-Jan. 2020, there were 856 households on a waitlist for an ODH-administered or ODM-funded program[46] who had a referral within the previous six months. This represents only 1% of the estimated number of Ohio families in need of home visiting services. Of these, 95.4% were on a waitlist for a Healthy Families America program.

Figure G.2 shows the counties with the highest numbers of families waitlisted. All are within the top seven most populated counties in Ohio and were identified as at-risk communities.

[46] This includes five families waitlisted for Moms & Babies First programs.

Figure G.2. **Ohio counties with the most households on a waitlist, Aug. 2019-Jan. 2020**

County	Number of households on waitlist	Percent of estimated number of households in need of home visiting on a waitlist
Franklin*	198	1.9%
Butler*	90	8.6%
Summit*	58	1.3%
Cuyahoga*	55	0.5%
Montgomery*	49	1%

* Indicates an at-risk community
Source: Ohio Department of Health

Figure G.3 shows the five counties with the largest percentages of their estimated number of families in need of home visiting on a waitlist. This signifies the percent of families in need of and wanting home visiting services that were not able to access them during August 2019 to January 2020. Only two of the five counties listed are at-risk communities (Butler and Meigs).

Figure G.3. **Ohio counties with the largest percentage of estimated number of households in need of home visiting on a waitlist, Aug. 2019-Jan. 2020**

County	Number of households on waitlist	Percent of estimated number of households in need of home visiting on a waitlist
Butler*	90	8.6%
Hancock	22	7.6%
Licking	17	5.9%
Meigs*	6	5%
Erie	26	4.8%

* Indicates an at-risk community
Source: Ohio Department of Health

Home visiting provider barriers to capacity

Online survey respondents were asked to identify the largest barriers impacting their ability to serve all pregnant women and families eligible for and requesting home visiting services. Figure G.4 shows the top three barriers identified for each county type. A map of Ohio county types is in Appendix C.1.

There was no barrier that was identified in the top three across all county types, but there were several that showed up in three of the four. Initial engagement, as well as referral challenges, showed up in the top three for all county types except for urban. Interestingly, two of the top challenges identified by urban counties did not show up in the top three for any other county types. These were funding and administrative burdens. The only other challenge that was unique to a county type was hiring challenges, which was in the top three for Appalachian counties only.

Figure G.4. **Largest barriers, by county type**

Urban counties N=44	Appalachian counites N=27	Suburban counties N=20	Rural, non-Appalachian counties N=28
Funding: All agency costs are not covered (27)	Home visiting model enrollee eligibility restrictions (15)	Initial engagement (11)	Initial engagement (18)
Retention (21)	Hiring challenges (15)	Home visiting model enrollee eligibility restrictions (9)	Retention (14)
Administrative burdens: Data reporting or data entry requirements/ challenges (14)	Initial engagement (12)	Lack of or problems with referral sources in the community (9)	Lack of or problems with referral sources in the community (14)
	Lack of or problems with referral sources in the community (12)		

= Unique to county type

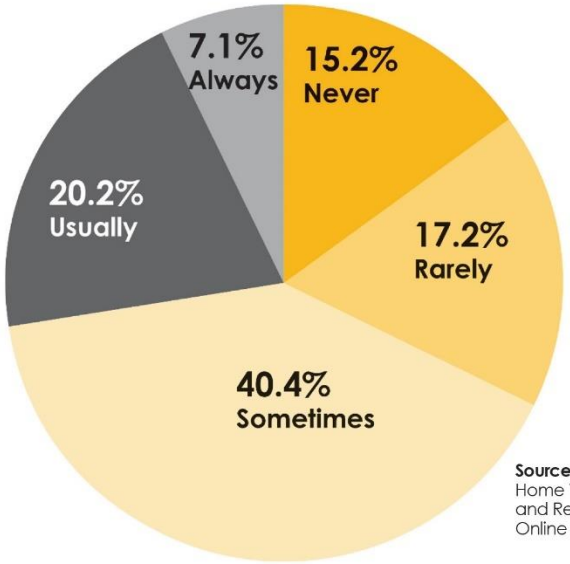
Note: Figure displays the top three responses. More than three responses may be listed when there are ties.
Source: HPIO analysis of Ohio Home Visiting Provider Capacity and Readiness Assessment Online Survey, May 2020

Home visiting staffing challenges

Survey respondents were asked about experiences with hiring and staff turnover. Responses are displayed in figure G.5.

There was consistency among the top reasons for hiring trouble across ODH-administered home visiting regions (see Appendix C.2 for map of home visiting regions). The top three reasons for the state overall were also in the top three for all regions except Region 5, for which barriers associated with training was the third most-commonly selected reason. See figure G.6.

Figure G.5. **"Do you have trouble finding and hiring qualified staff for home visitor positions?"** (N=99)



Source: HPIO analysis of Ohio Home Visiting Provider Capacity and Readiness Assessment Online Survey, May 2020

Figure G.6. **Top three reasons for having trouble hiring staff, by home visiting region**





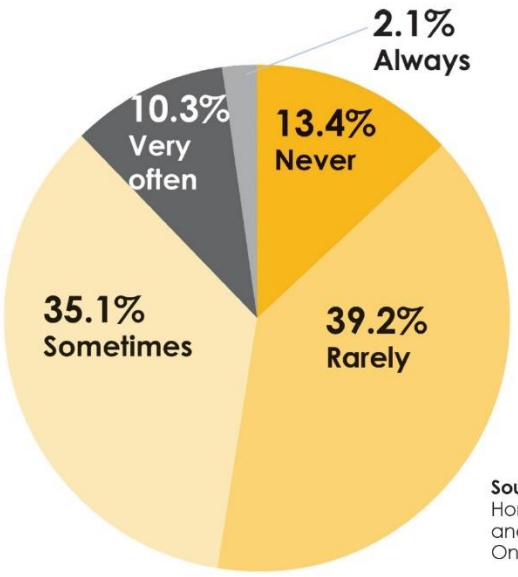

Region 1 N=9	Region 2 N=15	Region 3 N=11	Region 4 N=12	Region 5 N=12	Region 6 N=12
Candidates lack required experience or degrees (8)	Candidates lack required experience or degrees (9)	Compensation is too low to attract desirable candidates (10)	Candidates lack required experience or degrees (10)	Candidates lack required experience or degrees (7)	Candidates lack required experience or degrees (10)
Compensation is too low to attract desirable candidates (8)	Compensation is too low to attract desirable candidates (9)	Candidates lack required experience or degrees (8)	Compensation is too low to attract desirable candidates (10)	Compensation is too low to attract desirable candidates (6)	Compensation is too low to attract desirable candidates (9)
Candidates lack necessary knowledge and skills (2)	Candidates lack necessary knowledge and skills (8)	Candidates lack necessary knowledge and skills (5)	Candidates lack necessary knowledge and skills (5)	Barriers associated with training (5)	Candidates lack necessary knowledge and skills (5)

= Unique to region

Source: HPIO analysis of Ohio Home Visiting Provider Capacity and Readiness Assessment Online Survey, May 2020

Online survey respondents also reported challenges with staff turnover and retention (see figure G.7).

Figure G.7. **"Do you experience challenges with staff turnover and retention?"** (N=97)



Source: HPIO analysis of Ohio Home Visiting Provider Capacity and Readiness Assessment Online Survey, May 2020

Home visiting provider recommendations for systems improvement

Key informants and online survey respondents were asked to identify opportunities for systems improvement focused on state action. See responses in figures G.8 and G.9.

Figure G.8. **Key informant recommendations for improved state-level coordination and administration** (N=13)

Response	Number of respondents
Shared and comprehensive referral system	**7** (53.9%)
Coordination among state agencies	**6** (46.1%)
Improved data sharing	**4** (30.8%)
Funding/reimbursement model	**4** (30.8%)
Improved outcome and data tracking	**3** (23.1%)
Ohio Comprehensive Integrated Home Visiting Data System (OCHIDS) functionality	**3** (23.1%)
Credentialing requirements of home visitors	**3** (23.1%)
Coordinated state-level home visiting meetings	**2** (15.4%)
Implement Governor's Advisory Committee recommendations	**2** (15.4%)
Communication and coordination between national home visiting model and state	**1** (7.7%)
More timely communication (from ODH) to providers related to policy changes	**1** (7.7%)
Ensure fidelity to home visiting models	**1** (7.7%)
Facilitate partnerships among multiple home visiting programs in an area	**1** (7.7%)
Reduce administrative burdens on providers	**1** (7.7%)

Source: HPIO analysis of key informant interviews

Figure G.9. **Online survey responses to "How can Ohio's state agencies work more effectively and efficiently together to support home visiting in Ohio?"** (N=93)

Response	Percent
Promote common goals/collaboration between home visiting programs and partners	**16.1%**
Increase automatic referrals to home visiting (i.e., child abuse and neglect, Medicaid, WIC)	**16.1%**
Increase public education/awareness of home visiting	**11.8%**
Increase funding support to increase services	**8.6%**
Promote a unified home visiting approach	**8.6%**
Coordinate state-level home visiting meetings	7.5%
Increase communication among state agencies and other partners	7.5%
Increase training/funding to support staff supervision, training and retention	5.4%
Promote data sharing among state agencies and other partners	4.3%
Promote a comprehensive central intake system	3.2%
Promote consistent communication/guidance from state agencies to providers and families	3.2%
Provide family engagement and retention support	3.2%
Reduce administrative burden	3.2%
Expand eligibility/number of families being served	3.2%
Increase education/awareness of home visiting among partner agencies	3.2%
Support/fund family enrollment in complementary services/programs	2.2%
Engage additional partners	1.1%
Unsure	7.5%
Other	4.3%

Source: HPIO analysis of Ohio Home Visiting Provider Capacity and Readiness Assessment Online Survey, May 2020

Appendix H: Supplemental information on state-level initiatives

Family First Prevention Services Act planning

The federal Family First Prevention Services Act (FFPSA) was adopted in 2018 and will be implemented nationwide by Oct. 1, 2021. With the aim of keeping children out of foster care and with their families or relatives. This work aligns well with Governor DeWine's priorities.

The work to plan for the FFPSA is situated within the Ohio Department of Job and Family Services (ODJFS). A Family First Leadership Advisory Committee was created to make recommendations to ODJFS to guide the planning and implementation efforts. It is comprised of public and private organizations, advocacy groups, and youth and families with lived experience. The Committee released an Implementation Roadmap in April 2020, which includes:

- An over-arching vision for FFPSA in Ohio.
- Critical decisions required by FFPSA.
- Recommendations in relation to these critical decisions.
- Rationale for each recommendation.
- Key implementation considerations as the state moves forward, including projected action steps, timing and resource needs.

The state's vision for FFPSA planning is, "Ohio's children and families are safe, strong, connected, and empowered." The mission for FFPSA planning is, "To re-envision how Ohio ensures every child and family flourishes" by using Family First to leverage community connections and create data-informed resources for FFPSA implementation.

The Leadership Advisory Committee was divided into three subcommittees:

- Prevention [includes the following workgroups: In-home parenting; Mental health; Substance Use Disorder (SUD); Case flow process].
- Kinship/Adoption Navigator.
- Qualified Residential Treatment Programs (QRTP).

The Prevention subcommittee's goal was to design a prevention services plan that aligns evidence-based programs with the needs of Ohio's families and children to keep children safe and with their families whenever possible.

The whole subcommittee focused on defining candidacy while the workgroups built the evidence-based service array for prevention services in Ohio. The three HomVEE home-visiting models utilized through ODH's HMGHV (HFA, NFP and PAT) are included on the current list of in-home parent skill-based programs, as is SafeCare, Triple P and 11 other programs. The current list includes options for later prioritization.

The subcommittee received additional facilitation support from the Center for the Study of Social Policy (CSSP). The Prevention Services Subcommittee hosted a two-day planning retreat to discuss Ohio's plan to develop recommendations for a definition of

"candidate for foster care," draft a case flow map, and support the state in drafting a resource document for Ohio's prevention continuum.

More information about Ohio's FFPSA efforts can be found at http://jfs.ohio.gov/ocf/Family-First.stm.

Ohio Department of Medicaid's Maternal and Infant Support Program

In early 2020, the Ohio Department of Medicaid announced its plan to launch a Comprehensive Maternal and Infant Support Program. This will include:

- Medicaid reimbursement for nurse home visiting services.
- A new Mom & Baby Bundle care model that will expand relationships between clinicians and communities.
- Community investments through managed care focused on reducing Ohio's racial disparity in Black/African-American infant outcomes.
- A Mom & Baby Dyad model of care that supports mother and infant co-location when infants have neonatal abstinence syndrome and mothers have substance use disorder.
- Pursuing CMS approval for continuous 12-month Medicaid eligibility for postpartum women with substance use disorder.
- Refining Ohio's perinatal episode of care to account for tiering of risk.[47]

Office of Children's Services Transformation

Foster care is a focus of Ohio Governor Mike DeWine, which led to the creation of the Office of Children's Services Transformation within the Ohio Department of Job and Family Services. Its priorities include "enhancing state-county relationships, developing and sustaining best practices, and emphasizing the rights of children."

In response to the challenges facing both Ohio's children and providers/systems serving children, an additional $220 million was appropriated to the child welfare system in the SFY 2020-2021 state operating budget. To ensure effective use of those funds, Governor DeWine established the Children's Services Transformation Advisory Council[48] in November 2019 to "serve as special advisors to the Office of Children Service's Transformation and to evaluate and recommend needed foster care reforms; strengthen children services practices; and prioritize the safety, permanency, and well-being of Ohio's children and families."[49]

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[47] Ohio Department of Medicaid. *Ohio Medicaid's Mom & Baby Bundle*. Jan. 9, 2020. Accessed May 11, 2020.https://medicaid.ohio.gov/Portals/0/Initiatives/MISP/1-9-20-Mom-Baby-Bundle-Stakeholder-Deck.pdf

[48] Gov. Mike DeWine. "Executive Order 2019-27D: Creating the Governor's Children Services Transformation Advisory Council." Nov. 4, 2019. https://governor.ohio.gov/wps/portal/gov/governor/media/executive-orders/executive-order-2019-27da

[49] *Initial Findings Report.* Office of Children's Services Transformation. Feb. 2020. https://content.govdelivery.com/attachments/OHOOD/2020/02/05/file_attachments/1373438/Transformation%20Report%20020520.pdf

The Children Services Transformation Advisory Council is made up of a wide range of families, youth, and subject matter experts from across the state. They were tasked with conducting a top-down review of the state's child welfare system and developing recommendations to improve the experiences of children and families. The Council held 10 regional community foster care forums across the state to inform this work. The Council's final recommendations are due to the governor in summer 2020.

Figure H.1. **Performance measures tracked in OCHIDS**

Benchmark domains	Performance measures
Improved maternal and newborn health	*Preterm birth*
	Low birth weight
	Child well visits
	Developmental screening
	Breastfeeding
	Depression screening
	*Substance abuse/tobacco use**
	Postpartum care
Reduction in child injuries, abuse and neglect	*Child injury*
	Child maltreatment
	Safe sleep
	*Parent-child interaction**
	*Behavior concerns**
Improved school readiness and achievement	*Early language and literacy activities*
	*Parent-child interaction**
	*Behavior concerns**
Reduction in crime or domestic violence	*Intimate partner violence screening*
	*Substance abuse**
Improved family economic self- sufficiency	*Primary caregiver education*
	*Continuity of insurance coverage**
Improved coordination and referrals to community resources and supports	*Completed depression referral*
	Substance abuse/tobacco referral
	Completed developmental referral
	*Intimate partner violence referral**
	*Continuity of insurance coverage**
	Basic needs

* Measure is listed in more than one benchmark domain
Source: Ohio Department of Health

OCHIDS underwent updates based on the OCHIDS 3.0 IT project, which ran throughout 2019 and ended in February 2020. As part of this project, end users provided feedback on OCHIDS through a Lean Priority Survey conducted in June of 2019. The survey identified several OCHIDS programmatic areas requiring updates or enhancements. Figure H.2 provides a summary of survey results.

Figure H.2. **OCHIDS 3.0 IT Project Lean Priority Survey Results**

Data/report	number
A way for providers to extract raw data (would be helpful for providers with strong research interests and capacity to analyze)/ Ability to export data frequently and flexibly (variables needed)	11
Reports: Tools completion, caseload report (HFA levels, demographics, pending and missing tools) in real time	9
More reports in OCHIDS for required HFA reporting (and other required reporting)	8
A way to link system referral, program referral, eligibility and exit info into timeline for a single "session" of services	8
A customizable report builder for providers	7
Add capacity report	6
Save potential billing reports or billing details; filter by date	6
Benchmark monitoring (with individual data available- unlike dashboard snapshot)	3
Progress Note completion reports	3
Be able to see vouchers for each payment-- not by child but total	3
Report tab to full page of reports by topic	2
Simple reports on family demographics	2
Need to be able to see detail of payment selection-- travel, documentation, etc.	2
Enhanced historic billing reports	2

Source: Ohio Department of Health

Appendix I: Assessment of Ohio's capacity to provide substance use disorder treatment and counseling services

See Appendix I PDF